

Date Sent: currentDate.yyyymmdd

Select a surgeon:

- | | | |
|---|----------------------------|--------------------------|
| <input type="checkbox"/> Dr. Alexandra Easson | Phone: 416 946 2328 | Fax: 416 946 6590 |
| <input type="checkbox"/> Dr. Jaime Escallon | Phone: 416 586 5163 | Fax: 416 586 8847 |
| <input type="checkbox"/> Dr. Wey Liang Leong | Phone: 416 946 2992 | Fax: 416 946 4429 |
| <input type="checkbox"/> Dr. David McCready | Phone: 416 946 6510 | Fax: 416 946 6590 |
| <input type="checkbox"/> Dr. Michael Reedijk | Phone: 416 946 4432 | Fax: 416 946 6590 |

PATIENT INFORMATION

Last Name: patSurname		First Name: patFirstName		Date of Birth (dd/mm/yyyy): patBirthdate.short		Gender:	
Health Card #: patHN		Version: ...ionCode	Patient Location Details (Home/Inpatient):		Previous UHN Patient: Y / N <input type="checkbox"/> Yes <input type="checkbox"/> No		
Street Address: patStreetAddress							
City: patCityAddress			Province: patProvince			Postal Code: patPostalCode	
Phone (Home): patHomePhone.default		Phone (Cell): patMobilePhone.default		Phone (Work): patBusinessPhone.default			
Alternate Contact Name:		Relationship:			Phone (Home/Cell):		
Referring Physician Name: currMdName		Referring Physician Billing Number: currMdPhysNum		Referring Physician Phone: ...rrMdPhone.default		Referring Physician Fax: currMdFax.default	
Referring Physician Email: currMdEmail		Family Physician Name: patMdName		Family Physician Phone:		Family Physician Fax:	

***CLINICAL INFORMATION REQUIRED* (Please include as much information as possible and FAX COPIES OF ALL CONSULTATION/CLINICAL NOTES & REPORTS)**

Reason for Consultation: <input type="checkbox"/> Newly diagnosed <input type="checkbox"/> Second opinion <input type="checkbox"/> Recurrent/progressive disease <input type="checkbox"/> Undiagnosed abdominal mass <input type="checkbox"/> Other:	Diagnosis: Patient Informed of Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnostic Imaging/Reports: <input type="checkbox"/> Mammogram <input type="checkbox"/> Breast Imaging <input type="checkbox"/> X-ray <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Ultrasound <input type="checkbox"/> OR notes <input type="checkbox"/> Pathology <input type="checkbox"/> Other:
	Interpreter Services Requested? <input type="checkbox"/> No <input type="checkbox"/> Yes: please specify patient's primary language: patLanguage	Patient Has Also Been Referred To: <input type="checkbox"/> Medical Oncology <input type="checkbox"/> Radiation Oncology A separate referral form must be sent for each additional service requested.

REFERRING PHYSICIAN CHECKLIST FOR A COMPLETE REFERRAL

- Referral letter/Consult note
 Pathology reports
 Surgical procedure notes
 Diagnostic imaging reports
 Clinical notes
 Diagnostic imaging films & list of all medications given to patient to bring to appointment

NOTE: THIS PATIENT REMAINS UNDER THE CARE OF THE REFERRING PHYSICIAN UNTIL SEEN BY AN ONCOLOGIST AT PRINCESS MARGARET

OFFICE USE ONLY:

Date Received:	Appointment Date & Time:	Interpreter Booked? Y/N <input type="checkbox"/> Yes <input type="checkbox"/> No	Clinic:
Physician Signature:		Date:	Comments: