

Date Sent: currentDate.yyyysmmsdd

**Select a surgeon:**

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

**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)**

<b>Reason for Consultation:</b> <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:	<b>Diagnosis:</b>  <b>Patient Informed of Diagnosis?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Diagnostic Imaging/Reports:</b> <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:
	<b>Interpreter Services Requested?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes: please specify patient's primary language: patLanguage	<b>Patient Has Also Been Referred To:</b> <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:	