

CHECK LIST FOR A COMPLETE REFERRAL
(TO ACCOMPANY REFERRAL FORM)

- PATIENT DEMOGRAPHICS
(FULL NAME, GENDER, ADDRESS WITH POSTAL CODE
TELEPHONE NUMBER, HEALTHCARD NUMBER)
- REFERRAL LETTER
- PATHOLOGY REPORTS
- SURGICAL PROCEDURE REPORTS
- CLINICAL NOTES
- DIAGNOSTIC IMAGING REPORTS
- DIAGNOSTIC IMAGING FILMS GIVEN TO PATIENT
TO BRING TO APPOINTMENT
- FAXED TO 416-946-2900

NOTE

We will call the referring doctor's office with the appointment.
Please include on referral form, the name and telephone number of
the referring doctor

The New Patient Referral Center does not book for the Department
of Surgical Oncology - they must be booked through the Surgeon's
office.



610 University Avenue, Toronto, Ontario M5G 2M9

Phone: (416) 946-4575 1-800-711-0500

Fax: (416) 946-2900

University Health Network

Toronto General Hospital Toronto Western Hospital Princess Margaret Hospital

URGENT REFERRALS ARE HANDLED ON A DOCTOR TO DOCTOR BASIS

REFERRAL AND CONSULTATION FAX FORM

DATE RECEIVED:

MRN:

PATIENT INFORMATION		
Patient Name: patName	Title: patTitle	Date of Birth: ...te.yyyysmmsdd
Health Card Number: patHN	Version: ...rsionCode	Language: patLanguage
Address: patStreetAddress		
City: patCityAddress	Province: patProvince	Postal Code: ...talCode
Phone (home): patHomePhone.default	(work): patBusinessPhone.default	
Alternate Contact:	Relationship:	Phone:
Referring Physician: currMdName	Physican Number: ...dPhysNum	Phone: ...hone.default
Family Physician: patMdName	Physican Number: ...MdPhysNum	Phone:
CLINICAL INFORMATION (Please include as much information as possible and FAX COPIES OF ALL REPORTS)		
Diagnosis:	Inpatient: <input type="checkbox"/> Yes <input type="checkbox"/> No Where? Phone:	Patient Informed of Diagnosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for Consultation: <input type="checkbox"/> Newly Diagnosed <input type="checkbox"/> 2nd Opinion (must include 1st opinion notes) <input type="checkbox"/> Recurrent/ Progressive Disease <input type="checkbox"/> Other		
Explanation: Previous Cancer Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy: <input type="checkbox"/> Radiation Therapy: <input type="checkbox"/> Other: <input type="checkbox"/>		
Surgery: (Procedure, Date, Hospital)		Diagnostic Imaging: <input type="checkbox"/> X-Ray <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Ultrasound <input type="checkbox"/> Nuclear Med. Scan <input type="checkbox"/> Other:
Pathology: Slide/Specimen #;		
SPECIFY REQUESTED SERVICE <input type="checkbox"/> Radiation Oncology <input type="checkbox"/> Medical Oncology <input type="checkbox"/> Specific Oncologist		
REMINDER: Please send Diagnostic Imaging Films with Patient. <u>PLEASE INCLUDE REFERRAL LETTER</u>		
<u>FOR OFFICE USE ONLY</u>		
<u>PHYSICIAN'S INSTRUCTIONS:</u>		
<input type="checkbox"/> Give Appointment: Date: Time: Clinic: Physician:		
<input type="checkbox"/> Other Action: Specify:		
Physician Signature: <div style="border: 1px solid black; width: 200px; height: 30px; display: inline-block;"></div>		Date: