

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: [] Yes [] No
Where? Phone:
Patient Informed of Diagnosis
[] Yes [] No

Reason for Consultation:
[] Newly Diagnosed [] 2nd Opinion (must include 1st opinion notes)
[] Recurrent/ Progressive Disease [] Other
Explanation:

Previous Cancer Treatment:
[] Yes [] No
Chemotherapy:
Radiation Therapy:
Other:

Surgery: (Procedure, Date, Hospital)
Diagnostic Imaging:
[] X-Ray [] CT [] MRI [] Ultrasound
[] Nuclear Med. Scan
[] Other:
Pathology: Slide/Speciemen #;

SPECIFY REQUESTED SERVICE
[] Radiation Oncology [] Medical Oncology [] Specific Oncologist

REMINDER: Please send Diagnostic Imaging Films with Patient. PLEASE INCLUDE REFERRAL LETTER

FOR OFFICE USE ONLY

PHYSICIAN'S INSTRUCTIONS:
[] Give Appointment: Date: Time: Clinic:
Physician:
[] Other Action: Specify:

Physician Signature: [] Date: