



Princess Margaret Hospital
University Health Network

MRN: _____

GYNE ONC REFERRAL AND CONSULTATION FAX FORM

URGENT REFERRALS ARE HANDLED ON A DOCTOR TO DOCTOR BASIS

610 University Avenue, Toronto, Ontario M5G 2M9

Surgical Oncology Referral Fax Number: (416) 946 – 2288
 Surgical Oncology Urgent Referral Telephone Number: (416) 946 - 2254
Medical / Radiation Oncology Referral Fax Number: (416) 946 – 2900
 Medical / Radiation Onc. Urgent Referral Telephone Number: (416) 946 – 4575

Gynaecology Oncology: Medical Radiation Gynaecologic Oncology (Surgical) Colposcopy

Specific PMH Oncologist?

- No
 Yes (Please Specify)

Reason for Consultation:

- Newly Diagnosed 2nd Opinion
 Recurrent / Progressive Disease
 Undiagnosed pelvic mass
 Familial Ovarian Cancer Centre

Cancer Diagnosis: _____
 Has a referral been made to Clinical Trials? Y/N

Interpreter Services?

Language: _____

Patient informed of Dx?
 No Yes

PATIENT INFORMATION:

Patients Name:		Salutation:	Date of Birth:
Health Card Number:			Version Code:
Street Address:			
City:		Province:	Postal Code:
Phone: (Home)		Phone: (Cell)	Phone: (Work)
Alternate Contact:	Relationship:		Phone (Home / Cell):
Referring Physician:	Physician Billing Number:	Physician Fax Number:	Physician Phone:
Family Physician:	Physician Phone:		

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

***CLINICAL INFORMATION REQUIRED*:** (Please Note: A delay in appointment time may ensue should the information provided be insufficient) Please enclose all pertinent reports and include when faxing to PMH

Checklist:

- | | |
|---|---|
| <input type="checkbox"/> Referral Letter / Consult Note | <input type="checkbox"/> OR Note |
| <input type="checkbox"/> Surgical Pathology | <input type="checkbox"/> Recent PAP Smear |
| (Specimen # _____ Hospital: _____) | <input type="checkbox"/> CA 125 |
| <input type="checkbox"/> Diagnostic Imaging (Ultrasound, CT, MRI) | |

PMH OFFICE USE ONLY:

Appointment Date / Time:	Interpreter Booked? Y / N	Clinic:
Physician Signature:	Date:	Comments:

