DEPARTMENT OF RADIATION ONCOLOGY
PROP REFERRAL FORM
FOR URGENT REFERRALS CONTACT PHYSICIAN DIRECTLY
610 University Avenue, Toronto, Ontario M5G 2M9
Phone: 416 946 2901 Fax: 416 946 4657
Email: PROPReferrals@rmp.uhn.on.ca

Date Sent: _____

PALLIATIVE RADIATION ONCOLOGY PROGRAM (PROP)

PATIENT INFORMATION

Last Name:	First Name:	Date of Birth (dd/mm/yyyy):	Gender:

Health Card #:	Version:	Previous UHN Patient: Y/N? MRN, if known:

Street Address:	City:	Province:	Postal Code:

Phone (Home):	Phone (Cell):	Phone (Work):

Alternate Contact Name:	Relationship:	Phone (Home/Cell):

Referring Physician Name:	Referring Physician Phone:	Referring Physician Fax:

CLINICAL INFORMATION REQUIRED (Please FAX or EMAIL COPIES OF ALL APPROPRIATE NOTES & REPORTS)

DOCUMENTATION CHECKLIST:

☐ RELEVANT DIAGNOSTIC IMAGING ☐ RELEVANT DIAGNOSTIC REPORTS ☐ PATHOLOGY/OPERATIVE REPORT
☐ Images with Patient ☐ CLINICAL NOTES
☐ Images by other route Other:_____

Reason for Consultation:
☐ Spinal cord compression
☐ Bone metastases
☐ Brain metastases
☐ Chest metastases
☐ Other: _____

Symptom burden (0-10):
☐ High 7-10
☐ Moderate 4-6
☐ Low 0-3

Diagnosis and Reason for Referral:

_____

_____

_____

Symptoms Requiring Palliation:
☐ Pain
☐ Neurological symptoms
☐ Bleeding
☐ Respiratory symptoms
☐ Other:_____

Prior / Planned Therapy:
☐ Prior radiotherapy ☐ Yes ☐ No
If yes, PMH: ☐ Yes ☐ No Other center: ☐ Yes ☐ No Center:_____
☐ Planned chemotherapy ☐ Yes ☐ No
If Yes Date of next chemo: _____

PATIENT LOCATION:
☐ HOME ☐ OTHER ☐ IN-PATIENT: Where _____ Contact phone _____

PLEASE FAX TO (416) 946-4657 TELEPHONE : (416) 946-2901