

Date Sent: \_\_\_\_\_

Select a surgeon:

☐ Dr. Farshad Nassiri

**Phone: 416 603 5679**

**Fax: 416 603 5298**

☐ Dr. Paul Kongkham

**Phone: 416 603 5428**

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**PATIENT INFORMATION**

Last Name:		First Name:		Date of Birth (dd/mm/yyyy):		Gender:	
Health Card #:		Version:	Patient Location Details (Home/Inpatient):		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 Billing Number:		Referring Physician Phone:		Referring Physician Fax:	
Referring Physician Email:		Family Physician Name:		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"/> 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"/> 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: _____	<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	Clinic:
Physician Signature:		Date:	Comments: