UHN Princess Margaret Cancer Centre

THORACIC – DEPARTMENT OF SURGICAL ONCOLOGY REFERRAL FORM
FOR URGENT REFERRALS CONTACT PHYSICIAN DIRECTLY
610 University Avenue, Toronto, Ontario M5G 2M9

Date Sent: _____

☐ LungRAMP Program (Suspected primary lung cancer) **Fax: 416 340 3353**
☐ Earliest Available or ☐ Specific Surgeon *(see list below)*
☐ LungMets Program (Consideration of surgery for metastatic cancer spread to lung) **Fax: 416 340 3353**
☐ Suspected Esophageal Cancer **Fax: 416 340 3776**

For other considerations, contact the surgeon's office directly:

☐ Dr. Shaf Keshavjee (Phone: 416 340 4010) (Fax: 416 340 4556)
☐ Dr. Kazuhiro Yasufuku (Phone: 416 340 4290) (Fax: 416 340 3660)
☐ Dr. Thomas Waddell (Phone: 416 340 3432) (Fax: 416 340 4556)
☐ Dr. Marcelo Cypel (Phone: 416 340 5156) (Fax: 416 340 3478)
☐ Dr. Andrew Pierre (Phone: 416 340 5354) (Fax: 416 340 4556)
☐ Dr. Marc De Perrot (Phone: 416 340 5549) (Fax: 416 340 3478)
☐ Dr. Laura Donahoe (Phone: 416 340 4800 ext 6529) (Fax: 416 340 3660)
☐ Dr. Jonathan Yeung (Phone: 416 340 4800 ext 6529) (Fax: 416 340 3660)
☐ Dr. Elliot Wakeam (Phone: 416 340 5415) (Fax: 416 340 3660)

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/CLINCAL NOTES & REPORTS)

Reason for Consultation:
☐ Newly diagnosed
☐ Second opinion
☐ Recurrent/progressive disease
☐ Other:

Diagnosis:
_____

Patient Informed of Diagnosis?
☐ Yes ☐ No

Smoker?
☐ Yes ☐ No ☐ Former

Diagnostic Imaging/Reports:
☐ X-ray ☐ CT
☐ MRI ☐ Ultrasound
☐ OR notes ☐ Pathology
☐ Other:

Comments:
_____
_____
_____

Patient has also been referred to:
☐ Medical Oncology
☐ Radiation Oncology
A separate referral must be sent for each additional service requested.

Interpreter Services Requested?
☐ No
☐ Yes: please specify patient's primary language:

REFERRING PHYSICIAN CHECKLIST FOR A COMPLETE REFERRAL

☐ Referral letter/Consult note ☐ Pathology reports ☐ Clinical notes ☐ Diagnostic imaging reports ☐ Surgical procedure notes

Physician Signature:	Date:

Note: THIS PATIENT REMAINS UNDER THE CARE OF THE REFERRING PHYSICIAN UNTIL SEEN BY AN ONCOLOGIST