Esophageal Rapid Assessment & Management Program

URGENT REFERRAL FOR BENIGN OR MALIGNANT ESOPHAGEAL DISEASE

Toronto General Hospital | Tel: (416) 340 - 3383 | Fax: (416) 340 - 3776

PATIENT INFORMATION				
Last Name:	**First Name:**		**Date of Birth (dd/mm/yyyy):**	**Gender:** M F
Health Card #:	**Version:**	**Patient Location Details (Home/Inpatient):**	**Previous UHN Patient: Yes No 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:**	

Referral to: ☐ **EsoRAMP Program (Earliest Available) or**

☐ Dr E Wakeam ☐ Dr A Pierre ☐ Dr J Yeung

Please FAX consultant notes including HISTORY OF PATIENT, BLOOD WORK and CURRENT MEDICATIONS, X -RAY, CT SCAN, PATHOLOGY/CYTOLOGY & other PERTINENT REPORTS. **Patients MUST ARRIVE ON TIME and bring with them their HEALTH CARD and X-RAY OR CT-SCAN IMAGES.**

Clinical indication(s) for referral: ☐ CANCER ☐ SUSPICION FOR ESOPHAGEAL CANCER

☐ DYSPHAGIA ☐ REFLUX ☐ REGURGITATION

☐ OTHER, specify details:_____

Please include the following, if available:

☐ Endoscopy reports ☐ CT-scans (Chest, Abdomen/Pelvis) ☐ Tissue biopsy results ☐ Swallow studies

Other specify :_____

Please send IMAGING IF AVAILABLE WITH PATIENT

Date of Patient's initial consult with referring physician: _____
(mm/dd/yyyy)

Signature of Referring Physician (Mandatory) _____ **Date:** ____/____/____