UHN Canada's Hospital

Fax: 416-603-4257
Phone: 416-603-5800 x 8777

Multidisciplinary Metastatic Spine Clinic
Toronto Western Hospital
399 Bathurst St., 4 West Wing
Toronto, ON M5T 2S8

Date: _____

Patient Demographics

Last Name: _____ First Name: _____

Date of Birth: _____ Sex: _____ Phone: _____

OHIP: _____ Version Code: _____ Age: _____

Mailing Address: _____

Reason for Referral

Primary Disease Site: _____ ECOG Status: _____

Active Treatment: ☐ Radiation ☐ Systemic Therapy ☐ Other _____

Imaging: (CT/MRI must be performed in the last 3 months, or referral delays will occur)
☐ CT Chest Abdomen Pelvis ☐ CT Spine ☐ MRI Spine ☐ Other: _____

Specific referral questions:

_____
_____
_____
_____
_____

Referring Provider Information

Full Name of the Referring Attending MD / NP: _____

Referring MD/NP's Phone Number: _____

Referring MD/NP's Fax Number: _____

OHIP Billing Number: _____ Signature: _____

Please ensure all sections of this referral form are completed, and relevant documents including imaging reports included. Incomplete or illegible referrals will be returned. Thank you for your cooperation.