Princess Margaret Cancer Centre
UHN

MEDICAL and RADIATION ONCOLOGY NEW PATIENT REFERRAL FORM

610 University Avenue, Toronto, Ontario M5G 2M9
Phone: 416-946-4575, 1-800-711-0500 Fax: 416-946-2900
Email: NewPatientRegistrationAndReferrals@uhn.ca

FOR SURGICAL REFERRALS PLEASE CONTACT SURGEONS' OFFICES DIRECTLY

Referring to: ❑ MEDICAL ONCOLOGY & HEMATOLOGY ❑ RADIATION ONCOLOGY ❑ BOTH ❑ I DO NOT KNOW

PATIENT INFORMATION

Last Name:		Place Patient stamp or sticker here if available
First Name:		
Health Card #:	Version Code:	
Date of Birth (dd/mm/yyyy):		
Street Address:		
City:	Province:	Postal Code:
Phone (Home):	Phone (Cell):	Phone (Work):
Alternate Contact Name:	Relationship:	Phone (Home/Cell):
Fluent in English: ❑ Yes ❑ No	Preferred Language:	Are Interpretation Services required? ❑ Yes ❑ No

REASON FOR REFERRAL

❑ Newly diagnosed ❑ Recurrent disease ❑ Not yet diagnosed	❑ Currently on treatment: ○ Chemotherapy ○ Radiation	❑ Second Opinion (*please include First Opinion records*) ❑ Clinical Trials	Additional Information: _______________ _______________ _______________ _______________ _______________ _________

Patient Informed of Diagnosis? ❑ Yes ❑ No

MANDATORY REQUIREMENTS FOR REFERRAL PROCESSING

CLINICAL INFORMATION

Please include as much information as possible and FAX COPIES OF ALL CONSULTATION/CLINICAL NOTES & REPORTS

- ❑ **Disc with Diagnostic imaging & medications list given to patient to bring to appointment**
- ❑ Referral Letter/Consult Note
- ❑ Surgical Procedure Note (if any)
- ❑ Clinical Notes

Dates of Most Recent Diagnostic Tests:

- ❑ Pathology Report(s): Pathology: ______ / ______ / ______
- ❑ Diagnostic Imaging Reports : X-ray______/______/_______ CT: ______/______/_______
  Ultrasound: ______/______/_____ MRI:______/______/_______Mammogram: _____ /_____ / ______
  Please ensure patient brings copies of imaging on CD to first appointment
- ❑ Blood work: ______/______/_______
- ❑ Surgery: ______/______/_______

PRIMARY CANCER DIAGNOSIS

❑ BREAST	❑ GASTROINTESTINAL	❑ HEAD & NECK	❑ LYMPHOMA	❑ PALLIATIVE	❑ SARCOMA
❑ CNS	❑ GENITOURINARY	❑ LEUKEMIA	❑ MELANOMA	❑ PEDIATRICS	❑ SKIN
❑ ENDOCRINE	❑ GYNECOLOGIC	❑ LUNG	❑ MULTIPLE MYELOMA	❑ PHASE 1 CLINICAL TRIALS	❑ UNKNOWN PRIMARY

PHYSICIAN INFORMATION

Referring Physician Name:	OHIP billing #	Direct Referring Physician phone number:	Referring Physician Fax:
Referring Physician Email:	Family Physician Name:	Family Physician Phone:	Family Physician Fax:

PLEASE NOTE: THIS PATIENT REMAINS UNDER THE CARE OF THE REFERRING PHYSICIAN UNTIL SEEN AT PRINCESS MARGARET