UHN Princess Margaret Cancer Centre

GASTROINTESTINAL SURGICAL ONCOLOGY
NEW PATIENT REFERRAL FORM
Fax: 416-946-4631
Email:
GISurgicalOncologyReferrals@uhn.ca

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 or Pocket Health Imaging access**
- ❑ **Patient medication list**
- ❑ 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 the patient brings copies of imaging on CD to the first appointment or attach the Pocket Health access details

- ❑ Blood work:_______/______/_______
- ❑ Surgery:______/_____/_______

PRIMARY GASTROINTESTINAL CANCER DIAGNOSIS

❑ STOMACH	❑ SMALL BOWEL	❑ COLON	❑ RECTUM	❑ ANUS
❑ UNKNOWN PRIMARY	❑ OTHER			

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:

FOR ANY PATIENTS WITH ESOPHAGEAL, GASTROESOPHAGEAL, HEPATOBILIARY, PANCREATIC AND SARCOMA, PLEASE REFER TO THE RESPECTIVE SITE THROUGH THE REFERRAL FORMS AVAILABLE THROUGH THE PRINCESS MARGARET CANCER CENTRE WEBSITE

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