UHN Princess Margaret Cancer Centre

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

Date Sent: _____

Select a surgeon:

☐ First Available Physician		**Fax: 416 946 6590**
☐ Dr. Antonio Finelli	**Phone: 416 946 2851**	**Fax: 416 946 6590**
☐ Dr. Neil Fleshner	**Phone: 416 946 2899**	**Fax: 416 946 6590**
☐ Dr. Robert Hamilton	**Phone: 416 946 2909**	**Fax: 416 946 6590**
☐ Dr. Girish Kulkarni	**Phone: 416 946 2246**	**Fax: 416 946 6590**
☐ Dr. Jason Lee	**Phone: 416 340 3855**	**Fax: 416 340 4500**
☐ Dr. Nathan Perlis	**Phone: 416 946 2957**	**Fax: 416 946 6590**
☐ Dr. Alexandre Zlotta	**Phone: 416 586 4800x3910**	**Fax: 416 586 8354**

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):

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 of:
☐ Bladder/urothelial ☐ Prostate ☐ Kidney
☐ Testicular ☐ Other:_____

☐ Elevated PSA ☐ Abnormal DRE ☐ Hematuria ☐ Bladder mass
☐ Kidney mass ☐ Testicular mass ☐ Penile lesion
☐ Suspicious or confirmed biopsy (specify location): _____
☐ Abnormal ultrasound (specify location): _____
☐ Other: _____

Diagnostic Imaging/Reports:

☐ X-ray ☐ CT
☐ MRI ☐ Ultrasound
☐ TRUS reports ☐ DRE findings
☐ OR notes ☐ PSA results
☐ Pathology
☐ Other:
_____

Interpreter Services Requested?

☐ No ☐ Yes: please specify patient's primary language:_____

Diagnosis:

_____

Patient Informed of Diagnosis?

☐ Yes ☐ No

Patient Has Also Been Referred To:

☐ Medical Oncology
☐ Radiation Oncology
A separate referral must be sent for each additional service requested.

REFERRING PHYSICIAN CHECKLIST FOR A COMPLETE REFERRAL

☐ Referral letter/Consult note ☐ Pathology reports ☐ Surgical procedure notes ☐ Diagnostic imaging reports
☐ Clinical notes ☐ **Diagnostic imaging films & list of all medications given to patient to bring to appointment**

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

OFFICE USE ONLY:

Date Received:	Appointment Date & Time:	Interpreter Booked? Y/N	Clinic:

Physician Signature:	Date:	Comments: