UHN Princess Margaret Cancer Centre

SKIN AND MELANOMA –

Head and Neck SURGICAL ONCOLOGY REFERRAL FORM

FOR URGENT REFERRALS PLEASE CONTACT THE PHYSICIAN DIRECTLY

Date Sent: ______________________________

Please select Surgeon:	**PHONE**	**FAX**
❑ Dale Brown	416-340-3060	416-946-2300
❑ Douglas Chepeha	416-340-3082	
❑ John deAlmeida	416-340-3138	
❑ Ralph Gilbert	416-340-3145	
❑ David Goldstein	416-340-3062	
❑ Jon Irish	416-340-3113	
❑ Siba Haykal ***(Plastic Surgery)***	416-340-4327	416-340-4403

PATIENT INFORMATION

Last Name:

First Name:

Health Card #: | Version Code:

Date of Birth (dd/mm/yyyy):

Street Address:

City: | Province: | Postal Code:

Place Patient stamp or sticker here if available

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
❑ Second opinion
❑ Recurrent disease
❑ Not yet diagnosed

❑ Currently on treatment:
- ○ Chemotherapy
- ○ Radiation

DIAGNOSIS: ____
____
____

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

❑ Copy of Pathology report

❑ **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 to first appointment*

❑ Blood work:_______/______/_______

❑ Surgery:______/______/_______

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