UHN Princess Margaret Cancer Centre

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

Date Sent: _____

Select a surgeon:

- ☐ **Dr. Dale Brown** Phone: 416-340-3060, Fax: 416 946 2300
- ☐ **Dr. Douglas Chepeha** Phone: 416-340-3082, Fax: 416 946 2300
- ☐ **Dr. John de Almeida** Phone: 416-340-3138, Fax: 416 946 2300
- ☐ **Dr. Ralph Gilbert** Phone: 416-340-3145, Fax: 416 946 2300
- ☐ **Dr. David Goldstein** Phone: 416-340-3062, Fax: 416 946 2300
- ☐ **Dr. Patrick Gullane** Phone: 416-340-3098, Fax: 416 946 2300
- ☐ **Dr. Jonathan Irish** Phone: 416-340-3113, Fax: 416 946 2300
- ☐ **Dr. Christopher Yao** Phone: 416-340-3063, Fax: 416 946 2300
- ☐ **Dr. Jeremy Freeman** Phone: 416 586 5141, Fax: 416 466 6580
- ☐ **Dr. Eric Monteiro** Phone: 416 586 4800 x7954, Fax: 647 660 4350
- ☐ **Dr. Lorne Rotstein** Phone: 416 340 3573, Fax: 416 340 3808
- ☐ **Dr. Ian Witterick** Phone: 416 586 8313, Fax: 416 586 8583

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):	
Alternate Contact Name:	Relationship:	Phone (Home/Cell):	

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
- ☐ Other:

Diagnosis:

_____

Patient Informed of Diagnosis?
- ☐ Yes ☐ No

Diagnostic Imaging/Reports:
- ☐ X-Ray ☐ CT
- ☐ MRI ☐ Ultrasound
- ☐ OR notes ☐ Pathology
- ☐ Other:

_____

Patient Has Also Been Referred To:
- ☐ Medical Oncology
- ☐ Radiation Oncology

A separate referral must be sent for each additional service requested.

Interpreter Services Requested?
- ☐ No
- ☐ Yes: Please specify patient's primary language:

_____

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:	