UHN Princess Margaret Cancer Centre

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

Date Sent: _____

☐ Suspected **PRIMARY LUNG CANCER fax to LungRAMP (Fax: 416 340 3353):**
☐ **Earliest Available or** ☐ **Specific Surgeon** _____
☐ Consideration of surgery for **Pulmonary Metastatic disease fax to LungMETS (Fax: 416 340 3353)**
☐ Suspected **ESOPHAGEAL CANCER (Fax: 416 340 3776):** ☐ **Earliest Available or** ☐ **Specific Surgeon** _____

For other considerations contact a specific surgeon directly:
☐ Dr. Marcelo Cypel **(Phone: 416 340 5156) (Fax: 416 340 3478)**
☐ Dr. Gail Darling **(Phone: 416 340 3121) (Fax: 416 340 3660)**
☐ Dr. Marc De Perrot **(Phone: 416 340 5549) (Fax: 416 340 3478)**
☐ Dr. Shaf Keshavjee **(Phone: 416 340 4010) (Fax: 416 340 4556)**
☐ Dr. Andrew Pierre **(Phone: 416 340 5354) (Fax: 416 340 4556)**
☐ Dr. Thomas Waddell **(Phone: 416 340 3432) (Fax: 416 340 4556)**
☐ Dr. Kazuhiro Yasufuku **(Phone: 416 340 4290) (Fax: 416 340 3660)**

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: