UHN Princess Margaret Cancer Centre

SKIN AND MELANOMA – SURGICAL ONCOLOGY REFERRAL FORM

FOR URGENT REFERRALS PLEASE CONTACT THE PHYSICIAN DIRECTLY

Pls note: Head and neck is a separate form

Date Sent: _____

Select a surgeon based on disease site:

Trunk and Extremity	**FAX 416-586-8847**	Dr Alexandra Easson	Phone: 416-586-4800 ext 2775
		Dr Andrea Covelli	Phone: 416-586-5163
		Dr Wey Leong	Phone: 416-946-2992 Fax: 416-946-4429
		Dr Michael Reedijk	Phone: 416-946-4432 Fax: 416-946-4429
Gastrointestinal	**FAX 416-586-8847**	Dr Alexandra Easson	Phone: 416-586-4800 ext 2775
Gynecology	**FAX 416-946-2288**	Dr Stephane Laframboise	Phone: 416-946-2254
Plastic surgery	**FAX 416-340-4403**	Dr Siba Haykal	Phone: 416-340-4327

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
- ❑ 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 and medication list for 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:_____/_____/_____

  **Please ensure patient brings a CD copy of medical imaging and medical imaging reports 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