UHN Princess Margaret Cancer Centre

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

Date Sent: _____

Select a surgeon - Musculoskeletal Or Orthopaedic Surgical Oncology:

☐ Dr. Peter Ferguson	**Phone: 416 586 4800 ext. 8687**	**Fax: 416 586 8397**
☐ Dr. Jay Wunder	**Phone: 416 586 5995**	**Fax: 416 586 8397**

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

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

_____

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.

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:	