UHN Princess Margaret Cancer Centre

OCULAR ONCOLOGY REFERRAL FORM
FOR URGENT REFERRALS CALL 416-946-4501 x5572 DIRECTLY
610 University Avenue, Toronto, Ontario M5G 2M9
Phone: 416-946-4501 ext 5572 Fax: 416-946-2189

Date Sent: _____

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. Please Post or Email (Do Not Fax) images)

Reason for Consultation:
☐ Newly Diagnosed
☐ Second opinion
☐ Recurrent/Progressive disease
☐ Other:

_____

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

Details of Diagnosis: ☐ **Right Eye** ☐ **Left Eye**

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Primary Tumour location:
☐ Orbit ☐ Eyelid ☐ Conjunctiva
☐ Intraocular

Diagnostic Imaging/Reports:
☐ Ultrasound ☐ OCT
☐ IVFA ☐ CT
☐ MRI ☐ CXR
☐ OR notes ☐ Pathology
☐ Other
_____

Tumour Details (If possible):
Level:

Type:

Size:

REFERRING PHYSICIAN CHECKLIST FOR A COMPLETE REFERRAL

☐ Referral Letter/Consult Note ☐ Surgical Procedure Notes ☐ Diagnostic Imaging Reports ☐ Clinical Notes
☐ **Diagnostic Imaging Films & List of all Medications given to Patient to bring to appointment, if not previously sent**

NOTE: THIS PATIENT REMAINS UNDER THE CARE OF THE REFERRING PHYSICIAN UNTIL SEEN BY AN ONCOLOGIST AT PRINCESS MARGARET CANCER CENTRE

OFFICE USE ONLY:

Date Received:	Appointment Date & Time:	Interpreter Booked? Y/N	Physician:
Physician Signature:	Date:	Comments:	