

Date Sent: \_\_\_\_\_

**OUR TEAM:**

Dr. Marcus Bernardini	Dr. Sarah Ferguson	Dr. Rachel Kim	Dr. Cristina Mitric
Dr. Genevieve Bouchard-Fortier	Dr. Liat Hogen	Dr. Stéphane Laframboise	Dr. Lauren Philp

**PATIENT INFORMATION**

Last Name:		First Name:		Date of Birth (dd/mm/yyyy):	Gender:
Health Card #:		Version:	Phone (Home):	Phone (Cell):	
Street Address:					
City:			Province:	Postal Code:	
Alternate Contact Name:		Relationship:		Phone:	
Referring Physician Name:	Referring Physician <b>Billing Number</b> :	Referring Physician Phone:	Referring Physician Fax:		

**\*CLINICAL INFORMATION\***  
 We require the following information for your referral to be triaged.  
 Please **ONLY** send relevant reports to this referral.

<p><b>Reason for Consultation:</b></p> <input type="checkbox"/> Newly diagnosed <input type="checkbox"/> Second opinion <input type="checkbox"/> Recurrent/Progressive disease <input type="checkbox"/> Has patient been referred/or seen in another Gyn Oncology centre? <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Has patient seen: Med Onc <input type="checkbox"/> Yes <input type="checkbox"/> No Rad Onc <input type="checkbox"/> Yes <input type="checkbox"/> No	<p><b>Diagnosis:</b>        (clear indication why patient is referred)</p>   <p><b>Patient Informed of Diagnosis?</b>  <input type="checkbox"/> Yes   <input type="checkbox"/> No</p>	<p><b>Reports:</b></p> <input type="checkbox"/> Pathology report <input type="checkbox"/> OR note (if post-op) <input type="checkbox"/> Imaging – not older than 3 months and include ORADS Score (only include relevant imaging & bloodwork associated with specific referral)  <input type="checkbox"/> BMI: _____ or; Height: _____ Weight: _____
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**NOTE: THIS PATIENT REMAINS UNDER THE CARE OF THE REFERRING PHYSICIAN UNTIL SEEN BY AN ONCOLOGIST AT PRINCESS MARGARET CANCER CENTRE**