GYN MULTIDISCIPLINARY ONCOLOGY INTAKE FORM

Request for Gyn Oncology Program Consultation

Fax: 705-739-5636 Tel: 705-728-9090 ext 43155

Date of Referral (DD/MM/YYYY): _____

Consultation Requested: ❑ **Medical** ❑ **Radiation** ❑ **Surgical**
(check all that apply)

Referring Physician Information

Referring Physician | OHIP Billing #
( ) ( )
Phone # | Fax #

Primary Care Physician Information
❑ Same as Referring Physician

Primary Physician | OHIP Billing #
( ) ( )
Phone # | Fax #

Patient Information (please fill in as much as possible)

Patient Name | Date of Birth (DD / MM / YYYY)
( ) ( )
Street Address | Home Phone # | Business/Other Phone #
City, Province | Postal Code | Health Card # | Version | Expiry date

Reason for Referral

Date of Referral(DD/MM/YYYY): _____

Referral Reason (Diagnosis): _____

❑ New Diagnosis ❑ Follow-Up ❑ 2nd Opinion

❑ Recurrent /Progressive Disease

Clinical & Diagnostic Information (If known)

- ❑ Consult Note
- ❑ CA125 (if pelvic mass)
- ❑ Imaging (Ultrasound, CT Scan, MRI)
- ❑ Surgical Pathology
- ❑ Recent PAP Smear
- ❑ Operative Note
- ❑ Other _____

Cancer Diagnosis (If known)

- ❑ Suspicious Pelvic Mass
- ❑ Endometrial Cancer
- ❑ Vaginal Cancer
- ❑ Familial Breast & Ovarian Cancer
- ❑ Gestational Trophoblastic Disease
- ❑ Other _____
- ❑ Cervical Cancer
- ❑ Vulvar Cancer
- ❑ Ovarian Cancer
- ❑ Post Menopausal Bleeding (already seen by Gyn)

NOTE: This patient remains under the care of the referring physician until seen by our program.

SMRCP Staff Only:

Appointment Date:	Appointment Time:	Physician:
Notes:		