

Date: _____

HEAD & NECK Fax: 416-946-2300

- Dr. Dale Brown Phone: 416-340-3060
- Dr. John de Almeida Phone: 416-340-3138
- Dr. Ralph Gilbert Phone: 416-340-3145
- Dr. David Goldstein Phone: 416-340-3062

- Dr. Patrick Gullane Phone: 416-340-3098
- Dr. Jonathan Irish Phone: 416-340-3113
- Dr. Sharon Tzelnick Phone: 416-340-3147
- Dr. Christopher Yao Phone: 416-340-3063

OTOLOGY/NEUROTOLOGY Fax: 416-340-3327

- Dr. John Rutka Phone: 416-340-4630

GENERAL ENT Fax: 416-340-5116

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/CLINICAL NOTES & REPORTS)**

Reason for Consultation: <input type="checkbox"/> Newly diagnosed <input type="checkbox"/> Second opinion <input type="checkbox"/> Recurrent/progressive disease <input type="checkbox"/> Other:	Diagnosis: <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> Patient Informed of Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnostic Imaging/Reports: <input type="checkbox"/> X-Ray <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Ultrasound <input type="checkbox"/> OR notes <input type="checkbox"/> Pathology <input type="checkbox"/> Other:
Patient Has Also Been Referred To: <input type="checkbox"/> Medical Oncology <input type="checkbox"/> Radiation Oncology A separate referral must be sent for each additional service requested.	Interpreter Services Requested? <input type="checkbox"/> No <input type="checkbox"/> Yes: Please specify patient's primary language: <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>	<hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>

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: