

Date:

HEAD-START Fax: 416-946-2300

☐ Rapid Assessment and Biopsy for Suspicious Head & Neck Lesions
Phone: 416-340-5502

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. Christopher Noel Phone: 416-340-5186
☐ 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

☐ General Phone: 416-340-3668

PATIENT INFORMATION			
Last Name:		First Name:	
Date of Birth (dd/mm/yyyy):		Gender:	
Health Card #:	Version:	Patient Location Details (Home/Inpatient):	Previous UHN Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No
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 Other:	Diagnosis:		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 Other:
Patient Has Also Been Referred To: <input type="checkbox"/> Medical Oncology <input type="checkbox"/> Radiation Oncology <i>A separate referral must be sent for each additional service requested.</i>	Interpreter Services Requested? <input type="checkbox"/> No _____ <input type="checkbox"/> Yes: Please specify patient's primary language:		Patient Informed of Diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No

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