The Princess Margaret
Cancer Centre Foundation

Toronto General Hospital Toronto Western Hospital University Health Network

Department of Dentistry, Maxillofacial and Ocular Prosthetics
610 University Avenue Room 2 - 933, Toronto, Ontario M5G 2M9
TEL : (416) 946-2198 FAX : (416) 946-6576

* = Fields required

REFERRAL AND CONSULTATION FAX FORM

DATE RECEIVED: _____ MRN: _____

PATIENT INFORMATION

*Patient's Name:	Title:	*Date of Birth:
*Health Card Number:	Version:	*Language:
*Address: Street		
City:	Province	Postal Code
Phone: (home)	(work)	
*Alternate Contact:	Relationship:	Phone:
*Referring Physician:	Physician Number:	*Phone:
*Referring Dentist:	*Phone:	Fax:
* Referring Physician/Dentist email address:		

CLINICAL INFORMATION (Please include as much information as possible and FAX COPIES OF ALL REPORTS)

Diagnosis: Inpatient Yes ❒ No ❒ Where? Phone: Patient Informed of Diagnosis Yes ❒ No ❒

Reason for Consultation: Explanation:

❒Newly Diagnosed ❒2nd Opinion

❒Recurrent/ Progressive Disease ❒Other

Previous Cancer Treatment: Chemotherapy: Other:

Yes ❒ No ❒ Radiation Therapy:

Surgery: (Procedure, Date, Hospital)

Pathology: Slide / Specimen #:

Diagnostic Imaging:
X-Ray ❒ CT ❒ MRI ❒ Ultrasound ❒
Nuclear Med. Scan ❒
Other: ❒

SPECIFY REQUESTED SERVICE

❒Radiation Oncology ❒Medical Oncology ❒Surgical Oncology ❒Specific Oncologist

REMINDER: Please send Diagnostic Imaging Films (Radiographs) with Patient. PLEASE INCLUDE REFERRAL LETTER

COMMENTS:

Signature : _____