GYN MULTIDISCIPLINARY ONCOLOGY INTAKE FORM

Request for Gyn Oncology Program Consultation

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

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

Patient's Email | Name of Preferred Pharmacy

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.

HRCP Staff Only:

Appointment Date:	Appointment Time:	Physician:
Notes:		