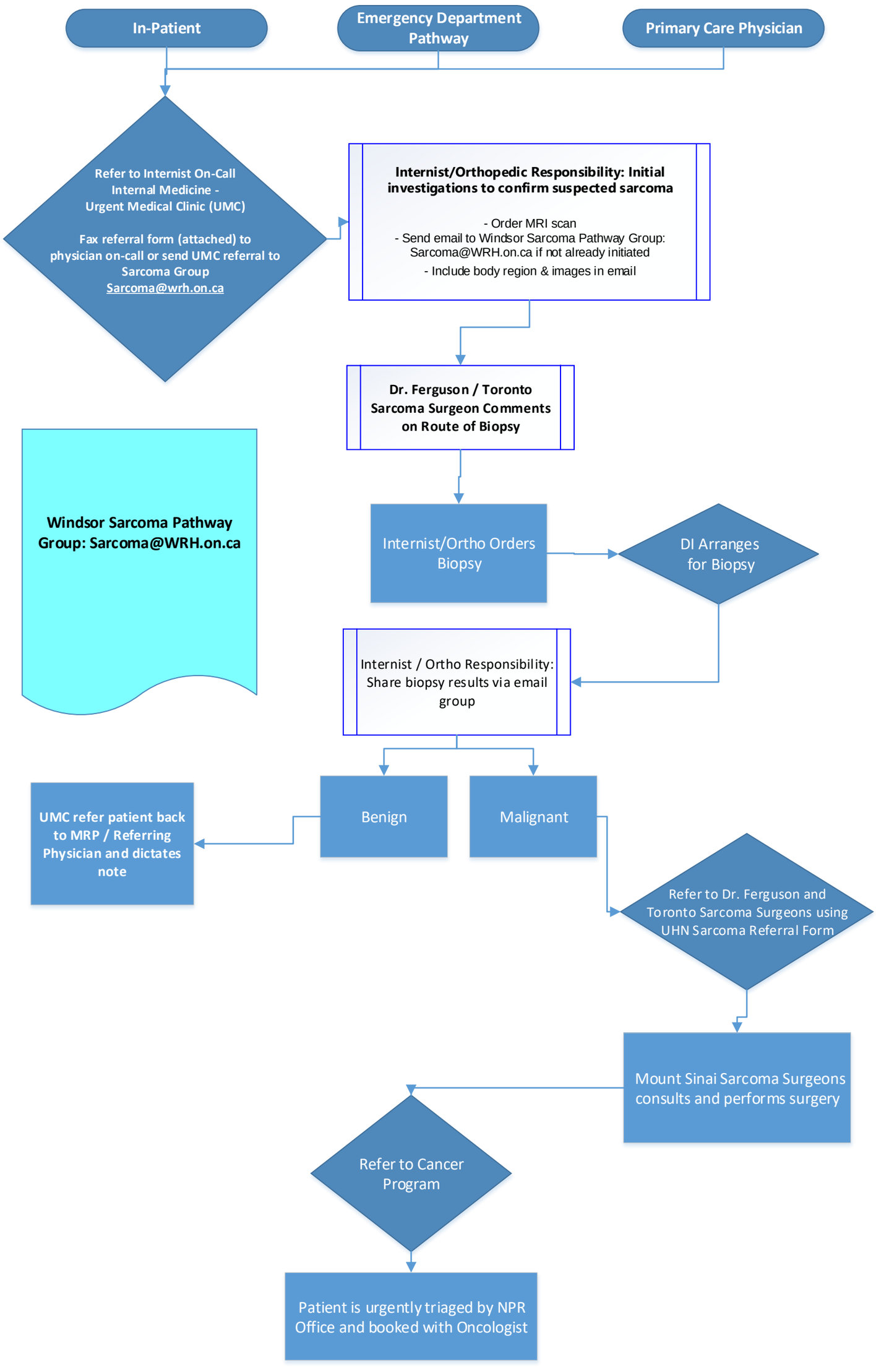
Orthopedic Sarcoma Pathway – Suspected Sarcoma Involving Limb



WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE - NO EXCEPTIONS!

Surname: _____

First Name: _____

Address: _____

_____

Phone #: _____

DOB: _____

OHIP #: _____

URGENT MEDICINE CLINIC REFERRAL FORM

Date: _____

Referring Physician: _____ Signature: _____

Provider Number: _____

Family Physician: _____

The following MUST BE completed by the REFERRING PHYSICIAN:
Reason for Referral (please print):

_____

_____

_____

_____

_____

_____

Completed Investigations (to be sent with referral):

☐ CT Scan	☐ MRI	☐ Ultrasound	☐ X-Rays
☐ Echo	☐ EKG (12 Lead)	☐ CBC	☐ Holter Monitor
☐ SMA-7	☐ Liver Panel	☐ Fasting glucose	☐ Cholesterol
☐ INR, PTT	☐ V/Q Scan	☐ Other (please specify): _____	

Please list Family Doctor above.

Information about appointments will be forwarded to the Family Doctor listed above.

Phone number for Urgent Medical Clinic is 519-973-4411 Ext. 3742

Fax this form to 519-255-2212

UHN Princess Margaret Cancer Centre

SARCOMA – DEPARTMENT OF SURGICAL ONCOLOGY REFERRAL FORM

FOR URGENT REFERRALS CONTACT PHYSICIAN DIRECTLY

610 University Avenue, Toronto, Ontario M5G 2M9

Date Sent: _____

Select a surgeon - Musculoskeletal Or Orthopaedic Surgical Oncology:

☐ Dr. Peter Ferguson	Phone: 416 586 4800 ext. 8687	Fax: 416 586 8397
☐ Dr. Jay Wunder	Phone: 416 586 5995	Fax: 416 586 8397

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/CLINCAL NOTES & REPORTS)

Reason for Consultation:

☐ Newly diagnosed
☐ Second opinion
☐ Recurrent/progressive disease
☐ Other:

_____

Diagnosis:

_____

Patient Informed of Diagnosis?

☐ Yes ☐ No

Interpreter Services Requested?

☐ No
☐ Yes: please specify patient's primary language:

_____

Diagnostic Imaging/Reports:

☐ X-ray ☐ CT
☐ MRI ☐ Ultrasound
☐ OR notes ☐ Pathology
☐ Other:

_____

Patient Has Also Been Referred To:

☐ Medical Oncology
☐ Radiation Oncology

A separate referral must be sent for each additional service requested.

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:	