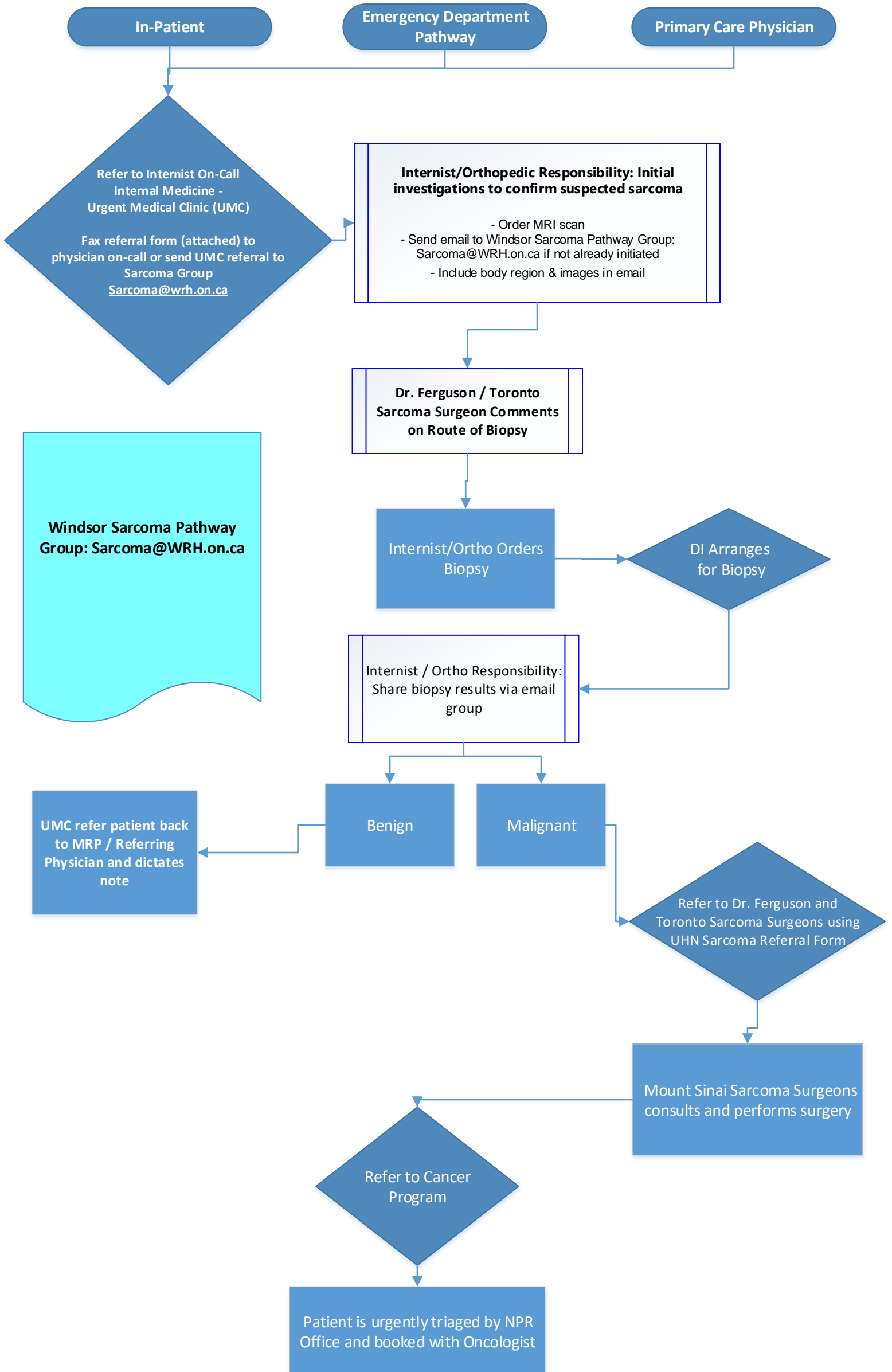


Orthopedic Sarcoma Pathway – Suspected Sarcoma Involving Limb



Orthopedic Sarcoma Pathway – Suspected Sarcoma Involving Limb

In-Patient

Emergency Department Pathway

Primary Care Physician

Refer to Internist On-Call Internal Medicine - Urgent Medical Clinic (UMC)
Fax referral form (attached) to physician on-call or send UMC referral to Sarcoma Group
Sarcoma@wrh.on.ca

Internist/Orthopedic Responsibility: Initial investigations to confirm suspected sarcoma

- Order MRI scan
- Send email to Windsor Sarcoma Pathway Group: Sarcoma@WRH.on.ca if not already initiated
- Include body region & images in email

Dr. Ferguson / Toronto Sarcoma Surgeon Comments on Route of Biopsy

Internist/Ortho Orders Biopsy

DI Arranges for Biopsy

Internist / Ortho Responsibility: Share biopsy results via email group

Benign

Malignant

UMC refer patient back to MRP / Referring Physician and dictates note

Refer to Dr. Ferguson and Toronto Sarcoma Surgeons using UHN Sarcoma Referral Form

Mount Sinai Sarcoma Surgeons consults and performs surgery

Refer to Cancer Program

Patient is urgently triaged by NPR Office and booked with Oncologist

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):

- | | | | |
|-----------------------------------|--|--|---|
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> MRI | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> X-Rays |
| <input type="checkbox"/> Echo | <input type="checkbox"/> EKG (12 Lead) | <input type="checkbox"/> CBC | <input type="checkbox"/> Holter Monitor |
| <input type="checkbox"/> SMA-7 | <input type="checkbox"/> Liver Panel | <input type="checkbox"/> Fasting glucose | <input type="checkbox"/> Cholesterol |
| <input type="checkbox"/> INR, PTT | <input type="checkbox"/> V/Q Scan | <input type="checkbox"/> 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



Date Sent: _____

Select a surgeon - Musculoskeletal Or Orthopaedic Surgical Oncology:

- | | | |
|---|-------------------------------|-------------------|
| <input type="checkbox"/> Dr. Peter Ferguson | Phone: 416 586 4800 ext. 8687 | Fax: 416 586 8397 |
| <input type="checkbox"/> 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/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: _____ 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: _____
Interpreter Services Requested? <input type="checkbox"/> No <input type="checkbox"/> Yes: please specify patient's primary language: _____		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.

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:		