# GYNECOLOGIC ONCOLOGY
# NEW PATIENT REFERRAL FORM

PHONE: 613-549-6666 EXT 6071 | FAX: 613-548-1330

Cancer Centre of Southeastern Ontario
A Cancer Care Ontario Partner
Kingston Health Sciences Centre | Centre des sciences de la santé de Kingston

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**HELP US TO SPEED UP YOUR PATIENT'S JOURNEY BY INCLUDING ALL SUPPORTING INFORMATION**

## PATIENT INFORMATION

| Last Name | First Name | DOB (yyyy/mm/dd) | Sex ☐ F \| ☐ M \| ☐ Other |
|---|---|---|---|

| OHIP/Version Code (or Other Insurance) | Address | City | Province | Postal Code |
|---|---|---|---|---|

| Primary Telephone | Alternate Telephone | Ext. | Other Telephone |
|---|---|---|---|

| Alternative Contact Person | Primary Telephone | Alternate Telephone |
|---|---|---|

Does the patient have special needs? ☐ Wheelchair ☐ Stretcher ☐ Transfer Service
☐ Interpretation – Language: _____
☐ Other: _____

| Primary Care Provider | Primary Care Provider Phone | Primary Care Provider Fax |
|---|---|---|

Is the patient aware that they are being referred to Gynecologic Oncology? ☐ Yes
☐ No – Reason: _____

## REFERRAL INFORMATION

Requesting (check all that apply): ☐ Consultation
☐ Multidisciplinary Cancer Conference Review (MCC)
☐ Pathology Review: Facility/Date: _____
Specimen #: _____
☐ Radiology Review: Facility/Date: _____
Imaging: _____

Reason for Referral:

If preferred Gyn-Oncologist is being requested, please provide name/reason: _____

## CLINICAL INFORMATION

| *REPORTS* | Attached | Pending | If Pending, Source/Date |
|---|---|---|---|
| Detailed Referral Letter | ☐ | ☐ | _____ |
| Operative Report | ☐ | ☐ | _____ |
| Pathology Report(s) | ☐ | ☐ | _____ |
| Labs | ☐ | ☐ | _____ |
| Up-to-Date Med List | ☐ | ☐ | _____ |

| *IMAGING* | Attached | Pending | If Pending, Source/Date |
|---|---|---|---|
| CT | ☐ | ☐ | _____ |
| Ultrasound | ☐ | ☐ | _____ |
| MRI | ☐ | ☐ | _____ |
| PET | ☐ | ☐ | _____ |
| Other | ☐ | ☐ | _____ |

## REFERRING PHYSICIAN INFORMATION

| Referring Physician Name | Referring Physician Telephone | Referring Physician Fax |
|---|---|---|

| Referring Physician Signature | Date (yyyy/mm/dd) |
|---|---|

*Referrals are triaged and booked according to urgency.*
*If you have requested a specific oncologist, please be advised this may affect wait times for your patient.*
*For emergent cases, the Referring Physician must call to speak with the Gyn-Oncologist on call.*

**To expedite the referral process, please ensure this form is completed in its entirety and all supporting documentation is included.**