



University Health Network

Toronto General Hospital Toronto Western Hospital Princess Margaret Hospital

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 information fields including Name, Title, Date of Birth, Health Card Number, Version, Language, Address, City, Province, Postal Code, Phone, Alternate Contact, Referring Physician, Referring Dentist, and Referring Physician/Dentist email address.

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

Clinical information fields including Diagnosis, Inpatient status, Where?, Phone, and Patient Informed of Diagnosis.

Reason for Consultation and Explanation fields, including checkboxes for Newly Diagnosed, Recurrent/ Progressive Disease, 2nd Opinion, and Other, along with Previous Cancer Treatment and Diagnostic Imaging details.

SPECIFY REQUESTED SERVICE

Requested service checkboxes: Radiation Oncology, Medical Oncology, Surgical Oncology, Specific Oncologist.

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

COMMENTS:

Comments section with multiple horizontal lines for text entry.

Signature: _____