UHN Princess Margaret Cancer Centre

PLASTIC & RECONSTRUCTIVE – DEPARTMENT OF SURGICAL ONCOLOGY REFERRAL FORM
FOR URGENT REFERRALS CONTACT PHYSICIAN DIRECTLY
610 University Avenue, Toronto, Ontario M5G 2M9

Date Sent: 02/07/2024 * Pls book urgently *. Present x > 2 years.

Select a surgeon:

☐ Dr. Stefan Hofer	Phone: 416 340 3449	Fax: 416 340 4403
☐ Dr. Toni Zhong	Phone: 416 340 3858	Fax: 416 340 4403
☐ Dr. Anne O'Neill	Phone: 416 340 3143	Fax: 416 340 4403
☒ Dr. Siba Haykal	Phone: 416 340 4327	Fax: 416 340 4403

PATIENT INFORMATION

Last Name: | First Name: | Date of Birth (dd/mm/yyyy): | Gender:

MRN: 500000009 HCN:
DXATESTING, STEPHANIE
SEX: F DOB: 22 MAY 1989
2089 BAYSVILLE AVENUE
BURLINGTON ON L5E 1Y5 T: 905-278-9808
DEPT: WSM OSTEO
PROV: KIM, SANDRA CSN:65284

Health Card: | Patient Location Details (Home/Inpatient): | Previous UHN Patient: Y / N | MRN, If Known:

Street Address: | City: | Province: | Postal Code:

Phone: | Phone (Work):

Alternate Contact Name: | Relationship: | Phone (Home/Cell):

Referring Physician Name:	Referring Physician Billing Number:	Referring Physician Phone:	Referring Physician Fax:
	031478		
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 breast cancer requiring immediate breast reconstruction
- ☐ Other types of immediate breast reconstruction (gene positivity, etc.)
- ☐ Delayed breast reconstruction
- ☐ Breast reconstruction revision
- ☐ Partial breast reconstruction
- ☐ Second opinion
- ☒ Other: 0.5 cm lesion (R) D2 finger. Pls see attached note. Pls see for consideration biopsy.

Diagnosis: P6 | foreign body | r/o malignancy

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

Dr. D. Dixon.

OFFICE USE ONLY:

Date Received:	Appointment Date & Time:	Interpreter Booked? Y/N	Clinic:

Physician Signature:	Date:	Comments: