Sunnybrook
ODETTE CANCER CENTRE
A Cancer Care Ontario Partner

General Skin Clinic
Fax-In Referral Form

Please FAX form and documents to
New Patient Booking Office: (416) 480-6179

Date of Referral (YYYY/MM/DD): _____

PATIENT IDENTIFICATION

Specific Service Required: ☐ Radiation Oncology ☐ Medical Oncology ☐ Surgical Oncology ☐ Dermatologist

Specific Odette Oncologist? ☐ No ☐ Yes (specify): _____

Reason for Referral? ☐ Consideration of therapy ☐ Second opinion ☐ Other (specify): _____

PATIENT INFORMATION:

Last Name:_____ First Name:_____

OHIP#:_____ Version Code:_____ DOB (D/M/Y):_____

Sex: ☐ Male ☐ Female ☐ _____ Does patient speak English? ☐ Yes ☐ No ☐ Other (specify):_____

Address:_____ City:_____ Postal Code:_____

Home Phone:_____ Business/Cell Phone:_____

Patient Location: ☐ Home ☐ Hospital (specify):_____

Other Contact Person Name and Phone Number:_____

DOCTOR INFORMATION:

Referring Physician:_____ Billing#:_____

Phone:_____ Ext._____ Direct Line:_____ Fax:_____

Family Physician:_____

Phone:_____ Ext._____ Direct Line:_____ Fax:_____

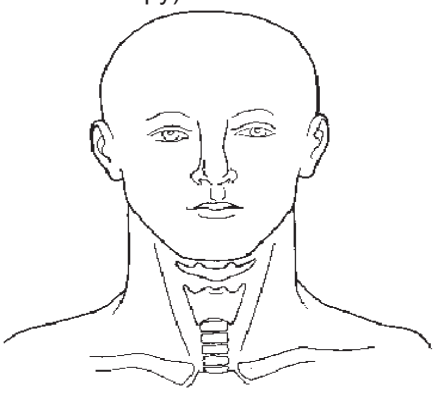
Surgeon:_____

Phone:_____ Ext._____ Direct Line:_____ Fax:_____

REFERRAL INFORMATION AND SUPPORTING DOCUMENTATION:

Diagnosis:
☐ Newly diagnosed ☐ Recurrent/progressive ☐ Rapidly growing

Site (indicate on diagram if on face):	**Tumour Size**	**Biopsy Done?** (please attach copy)
1. _____	_____	☐ Yes ☐ No
2. _____	_____	☐ Yes ☐ No
3. _____	_____	☐ Yes ☐ No



Additional History/Previous Treatment:_____

_____

Reports	Faxed	With Patient	Not Available
Referral Letter/H&P	☐	☐	☐
Operative/Brochoscopy	☐	☐	☐
Pathology Reports	☐	☐	☐
X-Ray Reports	☐	☐	☐

OCC OFFICE USE ONLY HFN:_____

Clinic Booked:_____ Date Booked:_____ Time Booked:_____

Clinic appointment called to: ☐ Referring Physician ☐ Hospital ☐ Patient ☐ Other (specify): _____

Slide Review Requested: ☐ Yes ☐ No

Phone Number: (416) 480-4205
We will contact the referring doctor with an appointment.

Referring Physician Signature: _____