Sunnybrook
ODETTE CANCER CENTRE
A Cancer Care Ontario Partner

Susan Leslie Neuroendocrine Tumor Clinic Referral Form

PATIENT IDENTIFICATION

Phone: 416-480-4205
Fax: 416-480-6179
net@sunnybrook.ca

Referral Date (YYYY/MM/DD):_________/__________/___________

PATIENT INFORMATION

Last Name: ______________________________ First Name: __________________________ DOB: _______________

OHIP card: ______________________________ Preferred Phone Number: _____________________________________

PHYSICIAN INFORMATION

Referring Physician: _____________________________________ OHIP billing #: ________________________________

Bus. Tel: ____ Fax: ____

REFERRAL FOR NEUROENDOCRINE TUMOR (or suspected neuroendocrine tumor)

☐ Stomach ☐ Small bowel ☐ Pancreas

☐ Colo-rectal ☐ Pancreas ☐ Broncho-pulmonary

☐ Metastases ☐ Other: ____

NOTE:
Your patient will receive an appointment with the multidisciplinary neuroendocrine tumor team at the Odette Cancer Centre (simultaneous assessment by medical, surgical, and radiation oncology). If appropriate, pathology review will be arranged upon referral.

MEDICAL HISTORY AND/OR OTHER PERTINENT INFORMATION

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REFERRAL REQUEST

☐ Earliest Appointment (expected 7-14 days)

FOR MORE INFORMATION OR TO USE OUR e-REFERRAL, PLEASE VISIT:

sunnybrook.ca/net