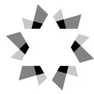

Mount Sinai Hospital
Sinai Health System
Joseph & Wolf Lebovic
Health Complex

600 University Avenue
Toronto, Ontario, Canada M5G 1X5

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Fax: 416-586-8392

Date Sent: (YYYY MM DD) ____________________

Clearly imprint patient identification card

THE PERITONEAL SURFACE MALIGNANCY PROGRAM REFERRAL FORM

Please select if you would like an appointment with the next available surgeon or with a specific surgeon:

☐ **Next available** **OR** ☐ **Dr. Andrea McCart/Dr. Danielle Bischof** **Phone: 416-586-4800 ext. 4552**

☐ **Dr. Anand Govindarajan** **Phone: 416-586-4800 ext. 7163**

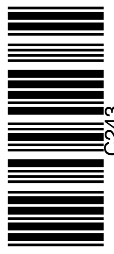
PATIENT INFORMATION

Last Name:	First Name:	Date of Birth (YYYY MM DD):	Gender:
Health Card #:	Version:		
Street Address:	City:	Province:	Postal Code:
Phone (Home):	Phone (Cell):	Phone (Work):	
Alternate Contact Name:	Relationship:	Phone (Home/Cell):	
Referring Physician Name and Billing Number:	Referring Physician Phone:	Referring Physician Fax:	

CLINICAL INFORMATION REQUIRED
(Please include all relevant information and FAX ALL APPROPRIATE CLINICAL NOTES & REPORTS)

DOCUMENTATION CHECKLIST FOR A COMPLETE REFERRAL

Reason for Consultation:	Diagnosis:	Diagnostic Imaging:
	Patient Informed of Diagnosis? ☐ Yes ☐ No	☐ CT ☐ MRI ☐ PET ☐ Other:
	Patient Has Also Been Referred To: ☐ Medical Oncology	**Interpreter Services Requested?** ☐ No ☐ Yes: please specify patient's primary language:



REFERRING PHYSICIAN CHECKLIST FOR A COMPLETE REFERRAL

☐ Referral letter ☐ Consult note ☐ Clinical notes ☐ Tumour marker reports
☐ Pathology reports ☐ Surgical reports ☐ Colonoscopy report ☐ Diagnostic imaging reports

DIAGNOSTIC IMAGING CDs MUST BE BROUGHT TO THE APPOINTMENT BY THE PATIENT