Radiotherapy RECOVERY CLINIC

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MedicalManagementofRadiationComplications

Fax Referral Form
1.844.714.1132

Referral Date (dd/mm/yyyy) _____

PATIENT INFORMATION

Last Name: _____ First Name: _____

Date of Birth (dd/mm/yyyy): _____ Health Card #: _____ Version: _____

Telephone #: _____

REASON FOR REFERRAL

Radiation Injury:

Onset Date (dd/mm/yyyy): _____ **OR** Duration: □1 □2 □3 □4 □5 □6 ☐ Day(s) ☐ Week(s) ☐ Month(s) ago

Cystitis ☐ Proctitis ☐ Osteoradionecrosis ☐ Ulcer ☐ Fibrosis ☐ Neurological ☐ Other: _____

Primary Oncologic Dx: _____ T ___ N ___ M ___

Surgical Rx: _____ Systemic Rx: [Chemo] _____ Radiotherapy Finish Date: (dd/mm/yyyy) _____

RADIOTHERAPY CX PRESENTATION

_____

_____

CLINICAL ASSOCIATIONS & MANAGEMENT

Associations:

☐ Pain ☐ Bleeding / Transfusion ☐ Infection ☐ Mobility issues ☐ Other: _____

Management to Date: _____

_____

TRIAGE PRIORITY

☐ Elective ☐ Semi-Urgent ☐ Urgent

REFERRING PHYSICIAN INFORMATION

Referring Physician: _____ Signature: _____

Specialty: _____ Telephone #: _____ OHIP #: _____