NORTH YORK GENERAL

Sunnybrook
TORONTO SUNNYBROOK REGIONAL CANCER CENTRE

PROSTATE CENTRE

A ppartnership between NYGH and Toronto Sunnybrook Regional Cancer Centre

AFFIX PATIENT LABEL HERE OR COMPLETE SECTION

PATIENT REFERRAL FORM

Phone: 416-635-2491
Fax: 416-635-2499

Date: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____

Address (Apt #): _____ City: _____ Postal Code: _____

Home: ( ) _____ Business: ( ) _____ Other: ( ) _____

Date of Birth: _____ Health Card #: _____ Version Code: ____
(DD/MM/YYYY)

REFERRING PHYSICIAN

Referring Physician Name: _____ Physician #: _____

Address: _____ City: _____ Postal Code: _____

Business: ( ) _____ Fax: ( ) _____

REASON FOR REFERRAL

Diagnosis:

- ☐ High PSA in the Absence of Urinary Infection / Instrumentation
- ☐ Abnormal Digital Rectal Examination
- ☐ Abnormal Ultrasound of Prostate
- ☐ Family History of Prostate Cancer

MEDICATIONS or ATTACH CUMULATIVE PATIENT PROFILE

_____
_____
_____
_____

ALLERGIES or ATTACH CUMULATIVE PATIENT PROFILE

_____
_____
_____
_____

REPORTS

PLEASE SEND THE FOLLOWING. REFERRALS WILL NOT BE PROCESSED WITHOUT THIS INFORMATION.

	Faxed	Not Applicable
Letter of Referral	☐	☐
Recent PSA Results	☐	☐
Reports of Previous Imaging &/or Biopsy	☐	☐