Lakeridge Health

Gynecologic Oncology
Diagnostic Assessment Program (DAP)

Fax: 905−721−7784 Toll Free: 1−877−291−5956
Tel: 905−576−8711 Toll Free: 1−866−338−1778
Ext. 32917

Patient last name:	First name:		
Address:	City	Postal Code	OHIP #
Birth date (dd/mm/yyyy)	Home phone #		Other phone #

By signing this form, you are confirming patient is aware of referral

Referring physician	Address	Phone # Fax #
Family physician (if not referring physician)	Address	Phone # Fax #
Signature of referring physician	Billing number	Date (dd/mm/yyyy)

Suspected/Confirmed cancer diagnosis:

☐ **Ovarian** (includes fallopian and peritoneal) ☐ **Cervical** ☐ **Endometrial/Uterine** ☐ **Vaginal** ☐ **Vulvar**

Clinical & diagnostic information (please include with referral)

☐ **Consult notes/history** − required for all referrals

☐ **Imaging** (required for Ovarian Cancer: trans−vaginal ultrasound or CT pelvis)

☐ Pathology (Preferred; Contact the DAP if you have concerns about obtaining pathology)

☐ Prior cytology

☐ Additional imaging: CT, MRI, Ultrasound

☐ Bloodwork

Other:

Additional clinical information; Reason for referral

For office use:

Appointment date	Appointment time	Physician
Notes:		

REF0087