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

☐ FIGO (grade 1) Bleeding greater than 12 months, BMI greater than 40, myometrial invasion on imaging, comorbidities, MMR deficiency, ER negative, P53 abnormal

Clinical & Diagnostic information (include with referral)

☐ Consult notes / history (required for all referrals; weight, comorbidities)

☐ 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 / bloodwork: CT, MRI, Ultrasound, Creatinine, CA125 for suspected ovary cancer

☐ Other: example; length / extent of bleeding for endometrial and cervix cancers

Reason for referral and any additional clinical information

REF0087