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. 2917

Central East Regional Cancer Program
in partnership with Cancer Care Ontario

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

Is patient aware of referral?
Yes ❑ No ❑

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:		