Radiotherapy Late Effects Clinic

A. Wayne Evans, MD

FAX Referral Form
1.844.714.1132

Ref. Date _____

Patient Information:

Last Name: _____ First Name: _____

DOB (dd/mmm/yy): _____/_____/_____ HC_____ VC _ _

Phone:_____ Alt_____

Reason for Referral: **Delayed Radiation Injury** Onset (date): _____ or 1 2 3 4 5 6 Dy Wk Mo ago

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

Primary Oncologic Dx: _____ T __ N __ M __

Surg Rx: _____ Systemic Rx [chemo]: _____ Radiotherapy (Finish Date): _____

Radiotherapy Cx Presentation:

Associations: Analgesia / Pain Management Bleeding /transfusion Infection

Management to date: Adjunctive Rx:

Triage: Elective ☐ Semi - urgent ☐ Urgent ☐

Doctor Information:

Referring Physician: _____ Signed _____

Specialty_____ Phone: _____ OHIP# _____

For any questions please call us at ph: 1.844.714.1132
Email: info@radiotherapylateeffects.com

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