London Health Sciences Centre

London Regional Cancer Program

REFERRAL MULTIDISCIPLINARY SKIN CARCINOMA CLINIC

FAX TO 519-685-8664

PIN #: .....

NAME: .....

ADDRESS: .....

.....

D.O.B (YYYY/MM/DD): .....

HEALTH CARD #: ..... VERSION: .....

DATE: (YYYY/MM/DD) _____

SUGGESTED TIME FRAME: ☐ Urgent ☐ Semi-Urgent ☐ Regular

REFERRING PHYSICIAN: **TELEPHONE No:**

FAX No:

Consultation Request:

☐ Cutaneous Oncology Multidisciplinary Clinic ☐ Radiation Therapy Only ☐ Photodynamic Therapy

☐ Other: _____

HISTORY / DURATION:

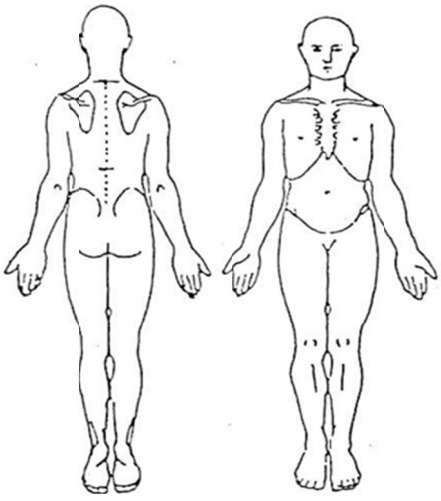
Working Diagnosis: (**MUST** include Biopsy/Pathology report) Patient Informed ☐ Yes ☐ No

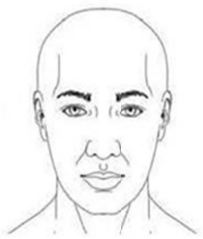
REASON FOR REFERRAL: (✓ Check all that apply)

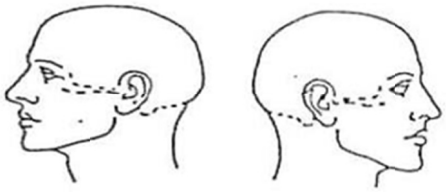
☐ Gross residual or recurrent disease after biopsy
☐ Complex reconstruction or cosmetic concerns
☐ Immunosuppressed
☐ Positive margins after excision
☐ Difficult to determine extent & depth
☐ Multiple, frequent skin cancers

SIZE/STAGING: (***Order CT** for primary site and nodal basins at time of this referral)

☐ No residual lesion (biopsy scar only)
☐ 2 cm or less
☐ 2 cm - 5 cm
☐ > 5 cm*
☐ Invades cartilage, skeletal muscles, or bone suspected*
☐ Poorly differentiated SCC*
☐ Perineural invasion or bone invasion*
☐ Palpable lymph nodes*
☐ Dermatofibrosarcoma*
☐ Atypical fibroxanthoma*







LRCP OFFICE USE:

Doctor/Service Request: _____ Reviewed by: _____

Physician Date