



**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



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:		