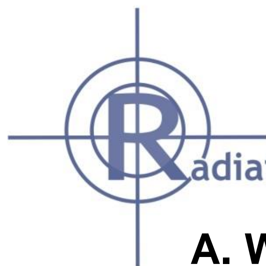

Radiation Therapy Complications Management

A. Wayne Evans, MD

FAX Referral Form

833.440.0202

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# _______________

If any questions please call us at ph 416 444-0202
E-Mail - info@rtcm.ca