



A. Wayne Evans, MD
Medical Management of Radiation Complications

Fax Referral Form
1.844.174.1132

Referral Date (dd/mm/yyyy) _____

PATIENT INFORMATION

Last Name: _____ First Name: _____

Date of Birth (dd/mm/yyyy): _____ Health Card #: _____ Version: _____

Telephone #: _____

REASON FOR REFERRAL

Radiation Injury:

Onset Date (dd/mm/yyyy): _____ **OR** Duration: 1 2 3 4 5 6 Day(s) Week(s) Month(s) ago

Cystitis Proctitis Osteoradionecrosis Ulcer Fibrosis Neurological Other: _____

Primary Oncologic Dx: _____ T ___ N ___ M ___

Surgical Rx: _____ Systemic Rx: [Chemo] _____ Radiotherapy Finish Date: (dd/mm/yyyy) _____

RADIOTHERAPY CX PRESENTATION

CLINICAL ASSOCIATIONS & MANAGEMENT

Associations:

Pain Bleeding / Transfusion Infection Mobility issues Other: _____

Management to Date: _____

TRIAGE PRIORITY

Elective Semi-Urgent Urgent

REFERRING PHYSICIAN INFORMATION

Referring Physician: _____ Signature: _____

Specialty: _____ Telephone #: _____ OHIP #: _____

For inquiries please call us at 1.844.714.1132
Email: info@rtrecovery.ca