REFERRAL FORM FOR TROPHOBLASTIC DISEASE PROGRAM

PLEASE FAX COMPLETED REFERRAL FORM TO 416-946-2288
For inquiries/concerns, please call our HOTLINE: 416-586-4800 ext 2704 or
email us at TDP@sinaihealthsystem.ca

☐ **Transfer of care**

OBSTETRIC HISTORY
Number of pregnancies including this one (G):
Number of live births (P):
Date of diagnosis: dd / mm / yyyy
Date of evacuation of hydatidiform mole: dd / mm / yyyy
Diagnosis:
Last Menstrual Period: dd / mm / yyyy
Gestational age (wks)
Family history of H.Mole? : YES ☐ NO ☐
Comment:

PATIENT IDENTITY / AFFIX LABEL	
Surname:	HCN:
First Names:	DOB: dd / mm / yyyy
Home Phone:	Cell/Work Phone:
Email:	
Preferred mode of communication: PHONE ☐ CELL ☐ EMAIL ☐ POST ☐	
If phone is preferred, may a voicemail be left? YES ☐ NO ☐	
Address:	
Language Spoken:	
Interpreter Required: YES ☐ NO ☐	

CLINICAL INFORMATION – X if applicable					
PV Bleeding	☐	Theca-lutein cysts	☐	Miscarriage	☐
Abnormal Ultrasound	☐	Enlarged Uterus for dates	☐	Abnormal HCG follow-up	☐

Serum hCG results at diagnosis:	Blood group / Rh:
Most recent hCG result:	Date of most recent hCG: dd / mm / yyyy

TREATMENTS			
Surgery	***D&C:*** YES ☐ NO ☐ Date: dd / mm / yyyy	***Hysterectomy:*** YES ☐ NO ☐ Date: dd / mm / yyyy	***Other:*** _____ Date: dd / mm / yyyy
Chemotherapy	***Specify Protocol:***	***Start date:*** dd / mm / yyyy	***Number of Cycles:***

REFERRING PHYSICIAN INFORMATION			
Name:	Institution:	Date:	Billing #
Address:			
Telephone:		Email:	
Signature: _____			

**** Please attach a copy of pelvic ultrasound, CXR, hcg levels, or relevant clinical notes if available ****