**WCH AFTER CANCER TREATMENT TRANSITION CLINIC (ACTT)**

**Gynecological Cancer Referral**

***Gyne***

**ACTT CLINIC FAX# 416-323-6001**

**ACTT PHONE#: 416-323-6400 EXT 3297**

**Translator required □ No □ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Eligibility (both required): □ within 5 years of Dx □ patient primary address in M postal code**

**ACTT Clinic Visit in \_\_\_\_ Months**

**Tests required on first visit to ACTT:**

**□ CA 125 □ U/S Abdo/Pelvis □ CT Abdo/Pelvis □ CT thorax □ Other\_\_\_\_\_\_\_\_\_\_\_\_**

**Vag Vaults Required □ No □ Yes Date of Last Cytology (MM/YY) \_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

**Site of Cancer: □ Cervix CA □ Endo CA □ Ovarian CA □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Stage: T\_\_\_\_N\_\_\_\_M\_\_\_\_ Date of Diagnosis: (MM/YY)** \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **MM/ YY** | **Type** |
| **/** |  |
| **/** |  |
| **/** |  |

**Surgical** **Procedures:**

**Chemotherapy: □ No □ Yes Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Radiation: □ N/A □ Yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fractions**

**Date Treatment Complete: (**MM/YY**) \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_**

**Post Treatment and Screening Issues (eg dilator use):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Referring Dr:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Med Onc □ Surg Onc □ Rad Onc**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**