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

 **Melanoma Referral**

***Melanoma***

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

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

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

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

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

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

**□ None □ Tests: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Site/Area of Melanoma:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Diagnosis (MM/YY) \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_**

**Size/Depth of Melanoma: \_\_\_\_\_\_\_\_\_\_\_\_\_ Clarks Level \_\_\_\_\_\_\_**

**Nodes Involved: \_\_\_\_\_\_\_ out of \_\_\_\_\_\_\_\_ nodes**

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

**Surgical** **Procedures:**

**Chemo/Immunotherapy: □ No**

**□ Yes Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Radiation: □ N/A □Yes (Location\_\_\_\_\_\_\_\_\_\_\_\_\_) (Fractions\_\_\_\_\_\_\_\_\_\_\_\_\_\_)**

**Post Treatment Concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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

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