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

**Testicular Cancer Referral**

***Testes***

**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 Contact Name/Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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

**□ Markers/Hormones □ Creatinine □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**□ CT Abdo/Pel/Thorax □ Chest X-ray**

**Site of Cancer: □ Testes □ Right □ Left □ Bilateral □ Other \_\_\_\_\_\_\_\_\_\_\_**

**□ Seminoma □ NonSeminoma Stage: T\_\_\_\_\_\_N\_\_\_\_\_M\_\_\_\_\_**

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

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

**Surgical** **Procedures:**

**Chemotherapy: □N/A**

**□Yes Type\_\_\_\_\_\_\_\_\_\_\_x \_\_\_\_\_\_cycles ending (MM/YY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Radiation: □ N/A □Yes # of Fractions\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Treatment and Screening Concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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