

R.A.A.M.P.

Rapid Assessment And Management Program

Windsor Professional Centre
2464 Howard Ave, Suite 202
P: 519-252-9861 x 5
F: 226-216-0643

Patient Information

Surname: _____ **DOB:** _____
Given Name: _____ **Gender:** F M
Address: _____ **Home Phone Number:** _____
City: _____ **Cell Phone Number:** _____
Postal Code: _____ **OHIP #:** _____

Referring Physician Information

Referring Physician: _____ **Referring Physician Billing:** _____
Referring Physician Phone #: _____ **Family Physician Fax #:** _____

If you belong to a FHT, FHO or FHG you will not be negated

Reason for Referral

1. RAPID ASSESSMENT (check what applies)

VTE - PE or DVT

Suspicious Skin Lesion

Abnormal CBC (check what applies)

Lymphadenopathy

Anemia : Microcytic Normocytic Macrocytic

Localized _____ Generalized

Pancytopenia

Leukopenia Thrombocytopenia

Suspicious Mass on Imaging (check what applies)

Leukocytosis Polycythemia Thrombocytosis

Breast Lung Pancreatic

Liver Bone CBD Dilatation

Unexplained Constitutional Symptoms (check what applies)

Renal Gyne Adrenal

Drenching night sweats OR fevers / chills

Other _____

Unintentional weight loss (>10% body weight in 3-6 months)

2. ROUTINE SCREENING (check what applies)

Breast Cervical Colon Other _____

3. SURVEILLANCE

Malignancy In Remission (ex. Breast, Melanoma, Hematologic, Colon) : _____

* Please attach medical history, updated medication list, and all relevant investigations including labs and imaging

Additional Notes

Revised December 2022

FOR OFFICE USE ONLY

DATE REFERRAL RECEIVED: _____

APPOINTMENT DATE: _____

APPOINTMENT TIME: _____