FirstHealth Oncology offers a board certified gynecologic oncologist for the evaluation and management of gynecological cancer. As part of the FirstHealth Outpatient Cancer Center a full range of services including education, support services, case management, symptom management and dietary services are available.

**Gynecologic Oncology Services Available**

- Management of gynecologic cancers to include ovarian, fallopian tube, primary peritoneal carcinoma, uterine/endometrial, cervical, vulvar, and vaginal cancers
- Advanced surgical management for complex pelvic disease
- Administration and management of chemotherapy for gynecological malignancies
- Long term surveillance for gynecological malignancies
- Advanced minimally invasive surgery; Robotic Surgery
- Palliative Supportive Care
- Genetic counseling and management for hereditary ovarian, breast and uterine cancers
- Management for suspected gynecological cancers to include pelvic masses
- Management of gynecologic cancer patients via tumor board
- Management of pre-invasive disease of the genital tract to include cervix, vulva and vagina
- Management of gestational trophoblastic diseases to include persistent / invasive molar pregnancies, chorio carcinoma, placental site trophoblastic diseases
To refer patients for a consult, call (910) 715-8684. Please give the patient a copy of this form to bring to his/her appointment. Records should be faxed at the time the appointment is made to (910) 715-8690.

Please provide the following patient information:

• Any diagnostic imaging that has been obtained related to the diagnosis in question (please send reports plus a disk or films if not in the FirstHealth PACS system)
• All pathology reports from any biopsies or surgeries
• Office notes
• All laboratory testing obtained thus far, including some old results, if available, for the tests that are now abnormal
• Demographics sheet with accurate address, phone numbers and copy of insurance cards.

**Consult Form**

Date ____________________             Appt Date/Time Given _______________

Contact Person _________________________________________________________________________________________

Phone # ____________________________________  Fax# ___________________________

Pt Name ________________________________________________________________ DOB __________________________

Med Rec # _______________________________________________________________ Rm# __________________________

Referring M.D. __________________________________________________________________________________________

Phone/Beeper# __________________________________________  Fax# __________________________

Address ______________________________________________________________________________________________

Primary M.D. ___________________________________________________________________________________________

Phone/Beeper# __________________________________________  Fax# __________________________

Surgeon ______________________________________________________________________________________________

Phone/Beeper# __________________________________________  Fax# __________________________

Type of Insurance __________________________________________ Policy# __________________________

Referral Required/Referral# ________________________________________________________________________________

**If New Patient:**

Address _______________________________________________________ Phone# _______________________________

Diagnosis ______________________________________________  Diagnosis Code ________________________________