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

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**FirstHealth Outpatient Cancer Center**
220 Page Road North • P.O. Box 3000 • Pinehurst, NC 28374
(910) 715-8684
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 ________________________________