McCain Centre for Pancreatic Cancer
610 University Avenue
G.I. Clinic, 4th floor, Room 4-743
Toronto, Ontario M5G 2M9
Tel. 416-946-2184 Fax: 416-946-2043

Please fax completed referral form with all relevant diagnostics to: 416-946-2043. The McCain Centre will confirm receipt of the referral and contact the patient with an appointment. Imaging must be downloaded to a CD and sent to the Centre ASAP. Lack of pertinent information will cause delays in the referral process.		
Last Name:	First Name:	Date of Birth (dd/mm/yy):
Gender:	Health Card #:	Version Code:
Patient Location Details (Home/Inpatient):	Specify Unit:	Unit Phone Number:
Street Address:		
City:	Province:	Postal Code:
Phone (Home):	Phone (Cell):	Phone (Work):

Referring Physician's Name:	Referring Physician's Billing Number:	Referring Physician's Phone:	Referring Physician's Fax:

Interpreter Required?
Yes □ If yes, what language does the patient speak: _____
No □

Referral Information: to be completed and signed by the referring Physician.	
Referral To: Medical Oncology □ Surgeon □ Unknown □	Date Sent:
Diagnosis:_____ Confirmed □ Presumptive □	
Is the patient aware of diagnosis? Yes □ No □ If no, please explain:_____	
Reason for Consultation: Newly Diagnosed □ 2nd Opinion Recurrent / Progressive Disease □ Clinical Trials □	

Required Information:	**Sent with Referral**	**If result pending state date and place done:**
1) **Letter** (with History & physical; co-existing conditions; allergies; previous malignancy; medication etc.)		
2) **Pathology**		
3) **Operative reports**		
4) **Imaging** CT/US/MRI/XRAY		
5) **Blood work** (bili, liver enzymes etc.)		
7) **CA 19-9**		

Comments