Wallace McCain Centre for Pancreatic Cancer
620 University Ave
8th Floor, Rm 8-132 Toronto,
ON M5G 2C1
Princess Margaret Cancer Centre
University Health Network
Email: McCainCentre@uhn.ca
Phone: 416-946-2184 **Fax: 416-946-2043**

Last Name:	First Name:	Date of Birth (dd/month/yyyy):
Gender:	Health Card #:	Version Code:
Patient LocationDetails (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:
Referring Physician's Signature:		Date:	

PLEASE NOTE: THIS PATIENT REMAINS UNDER THE CARE OF THE REFERRING PHYSICIAN UNTIL SEEN AT PRINCESS MARGARET

Referral Information: to be completed and signed by the referring Physician.

Referral To:
☐ Medical Oncology ☐ Surgeon ☐ Radiation Oncology ☐ Unknown

Diagnosis:
☐ Confirmed ☐ Presumptive

Is your patient aware of the reason for the referral and the potential or known diagnosis?
☐ Yes ☐ No If No, please inform your patient prior to sending the referral.

Reason for Consultation:
☐ Newly Diagnosed ☐ 2nd Opinion ☐ Recurrent ☐ Progressive Disease ☐ Clinical Trials

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

MANDATORY REQUIREMENTS FOR REFERRAL PROCESSING

Required Information:	**Sent with Referral**	**If result pending, state date and place done:**
1) **Med/Rad Oncology, Surgeon Notes**	☐	
2) **HPI; PMHx; allergies; medication**	☐	
3) **Pathology Report**(s)	☐	
4) **Operative/Procedure Report**(s)	☐	
5) **Genetic/Genomic Report** (s)	☐	
6) **Imaging** CT/US/MRI	☐	
7) **Blood work**	☐	
8) **CA 19-9 Level**	☐	

Comments

INCOMPLETE OR MISSING INFORMATION MAY RESULT IN DELAYS OR PREVENT YOUR REFERRAL FORM BEING PROCESSED. PLEASE ENSURE ALL REQUIRED FIELDS ARE FILLED OUT ACCURATELY TO AVOID DELAYS.