UHN Princess Margaret Cancer Centre

HEPATOBILIARY/PANCREATIC – DEPARTMENT OF SURGICAL ONCOLOGY REFERRAL FORM
FOR URGENT REFERRALS CONTACT PHYSICIAN DIRECTLY
610 University Avenue, Toronto, Ontario M5G 2M9

Date sent: _____

Completed referrals can be faxed to 1-866-547-2844.
For Urgent Surgical Assessment contact the HPB surgeon on call through UHN locating: 416-340-3155.
Follow up calls and inquiries can be directed to 416-340-4400.

☐	**Dr. Steve Gallinger**	**Phone: 416 340 4412**	**Fax: 416 340 3808**
☐	**Dr. Ian McGilvray**	**Phone: 416 340 5230**	**Fax: 416 340 5242**
☐	**Dr. Carol-Anne Moulton**	**Phone: 416 340 5336**	**Fax: 416 340 3808**
☐	**Dr. Gonzalo Sapisochin**	**Phone: 416 340 5169**	**Fax: 416 340 3237**
☐	**Dr. Chaya Shwaartz**	**Phone: 416 340 4800 ext 2967**	**Fax: 416 340 5242**
☐	**Dr. Trevor Reichman**	**Phone: 416-340-4800 ext 5404**	**Fax: 416 340 4039**

PATIENT INFORMATION

Last Name:	First Name:	Date of Birth (dd/mm/yyyy):	Gender:
Health Card #:	Version:	Patient Location Details (home/inpatient):	Previous UHN Patient: Y / N MRN, if Known:
Street Address:			
City:	Province:	Postal Code:	
Phone (Home):	Phone (Cell):	Phone (Work):	
Alternate Contact Name:	Relationship:	Phone (Home/Cell):	
Referring Physician Name:	Referring Physician Billing Number:	Referring Physician Phone:	Referring Physician Fax:
Referring Physician Email:	Family Physician Name:	Family Physician Phone:	Family Physician Fax:

CLINICAL INFORMATION REQUIRED (Please include as much information as possible and FAX COPIES OF ALL CONSULTATION/CLINCAL NOTES & REPORTS)

Reason for Consultation:
- ☐ Newly diagnosed
- ☐ Second opinion
- ☐ Recurrent/progressive disease
- ☐ Other: _____

Diagnosis: _____

Patient Informed of Diagnosis?
- ☐ Yes
- ☐ No

Diagnostic Imaging/Reports:
- ☐ X-ray
- ☐ CT
- ☐ MRI
- ☐ Ultrasound
- ☐ OR notes
- ☐ Pathology
- ☐ Other: _____

Patient has also been referred to:
- ☐ Medical Oncology
- ☐ Radiation Oncology

Note: A separate referral must be sent for each additional service requested.

Interpreter Services Required?
- ☐ Yes
- ☐ No

Language: _____

REFERRING PHYSICIAN CHECKLIST FOR A COMPLETE REFERRAL

- Referral letter
- Pathology reports
- Surgical procedure notes
- Consult notes
- Clinical notes
- Diagnostic imaging CDs & reports

NOTE: THIS PATIENT REMAINS UNDER THE CARE OF THE REFERRING PHYSICIAN UNTIL SEEN BY AN ONCOLOGIST AT PRINCESS MARGARET HOSPITAL

OFFICE USE ONLY:

Date Received:	Appointment Date & Time:	Interpreter Booked? Y/N	Clinic:
Physician Signature:	Date:	Comments:	