Wallace McCain Centre
FOR PANCREATIC CANCER
PROUD MEMBER OF UHN

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/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:
Referring Physician's Signature:			

Referral Information: to be completed and signed by the referring Physician.	
Referral To: (please circle) ☐Medical Oncology ☐Surgeon ☐Unknown	Date Sent:
Diagnosis: Please circle: ☐Confirmed ☐Presumptive	
Is your patient aware of the reason for the referral and the potential or known diagnosis? Please circle: ☐Yes ☐No If No, please inform your patient prior to sending the referral.	
Reason for Consultation: (please circle) ☐Newly Diagnosed ☐2nd Opinion ☐Recurrent ☐Progressive Disease ☐Clinical Trials	
Interpreter Required? (please circle) ☐Yes ☐No If yes, what language does the patient speak:	

Required Information:	**Sent with Referral**	**If result pending, state date and place done:**
1) **Letter** with HPI; PMHx; allergies; medication	☐	
2) **Pathology Report**(s)	☐	
3) **Operative Report**(s)	☐	
4) **Imaging** CT/US/MRI/XRAY	☐	
5) **Blood work**	☐	
6) **CA 19-9 Level**	☐	

Comments

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. Lack of pertinent information will cause delays in the referral process.