Trillium Health Partners

Mississauga Halton Central West Regional Cancer Program
in partnership with Cancer Care Ontario

Reset Form

HEPATO-PANCREATIC BILIARY DIAGNOSTIC ASSESSMENT PROGRAM REFERRAL FORM

DAP FAX: 1-877-530-4425 DAP OFFICE MAIN: 1-866-530-4464

Referral Date: _____

Translator Required? ☐ Y | ☐ N Language: _____ Unit #: _____

PATIENT INFORMATION (AFFIX PATIENT LABEL)	REFERRING PHYSICIAN INFORMATION (STAMP)
Last Name:	Referring Physician Name:
First Name:	Address:
Health Card #: V.C.:	Phone:
Date of Birth:	Fax:
Address:	Billing #:
City:	Family Physician name:
Province: Postal Code:	***Referring Physician Signature:***
Phone #1:	
Phone #2:	
Phone #3:	

REASON FOR REFERRAL *(Required)*

☐ Pancreatic mass

☐ Liver mass

☐ Gallbladder/Biliary mass

☐ Other (please indicate) _____

DIAGNOSTIC INFORMATION:

Please indicate if any of the following tests have been completed and attach report:

Blood Test:	Report Attached	**Diagnostic Imaging:** **Patient **must** bring disk to appointment*	Report Attached
LFT (INR,Bili)		CT*	
AFP		MRI*	
CEA		CXR	
CA19-9		PET Scan	
Chronic Hepatitis Serology		2D Echo	
Glucose, BUN, Creatinine, Lytes			

Other Relevant Information:

FOR REFERRAL OFFICE USE ONLY

Date Received: _____ Surgeon (please check): ☐ Wen ☐ Garzon

First Navigator Patient Contact	Date: _____	Time: _____	Signature: _____
Date of CT	Date: _____	Time: _____	Signature: _____
Date of MRI test ☐ N/A	Date: _____	Time: _____	Signature: _____
Date of Surgical Consult	Date: _____	Time: _____	Signature: _____
Pt Notified of Appointment	Date: _____	Time: _____	Signature: _____

2865 D HR (February/2017)