St. Michael's Hospital
Pancreatic Diseases Program
Division of Gastroenterology
30 Bond St., Toronto, ON. M5B 1W8
Phone: 416-864-5492; Fax: 416-864-5882

REFERRAL FORM
PANCREATIC DISEASES PROGRAM

Thank you for referring to the PANCREATIC DISEASES CLINIC. Please fax this form to 416-864-5882. If you require additional assistance, please call 416-864-5492

PATIENT INFORMATION

Last Name:	City:
First Name:	Province:
Gender:	Postal Code:
Health Card # and version code:	Phone (home): Cell:
Street Address:	Phone (work):

REFERRING PHYSICIAN

Name	Signature
Date sent (dd/mm/yyyy):	Billing #

- **REASON FOR REFERRAL**: _____
- **IS THIS A PATIENT FOR TRANSITION FROM PEDS TO ADULT? YES ○ NO ○**

Please include the following:	**Included**	**Pending**
a. Referral letter (HPI, PMH, meds)	○	○
b. Genetic testing (if done)	○	○
c. Operative reports	○	○
d. Imaging results (CT/MRI/US/EUS)	○	○
e. Blood work	○	○