Odette Cancer Centre Telemedicine OTN
HPB Surgery Fax-In Referral Form

Please **FAX** *form and documents to Jessica Maullon:*
(416) 480-6002

Date of Referral: _____

Site: ☐ Liver ☐ Pancreas ☐ Bile Duct ☐ Gallbladder
☐ Other, Specify:

Specific Service Required: ☐ Surgical Oncology ☐ Second Opinion

Diagnosis:

Patient Information:

Last Name:_____First Name:_____
OHIP#: _____ Version Code:_____ DOB(*D/M/Y*):____/____/_____
Sex: M / F Does patient speak English? ☐Yes ☐No ☐ Other (specify):_____
Address:_____City_____Postal Code_____
Home Phone:_____Business/Cell Phone:_____
Patient Location: ☐ Home ☐ Hospital (specify):_____
Other Contact Person Name and Phone Number:

Doctor Information:

Referring Physician:_____Billing #:_____
Phone:_____ ext._____*Direct Line*:_____ *Fax*:_____
Family Physician:_____
Phone:_____ ext._____ *Direct Line*:_____ *Fax*:_____
Surgeon:_____
Phone:_____ ext._____*Direct Line*:_____ *Fax*:_____

Referral Information and Supporting Documentation:

Patient Informed of Diagnosis? ☐Yes ☐No	Date of surgery/biopsy *(D/M/Y)*____/____/_____ ☐ N/A
Specific OCC oncologist?☐ No ☐ Yes (specify)	
Treatment Setting: ☐ New ☐ Recurrent/Progressive ☐ Other: _____	
Date of Previous anti-cancer treatments: ☐Chemotherapy_____☐Hormonal Therapy_____☐Other(specify)_____	
Date of Current anti-cancer treatments: ☐Chemotherapy_____☐Hormonal Therapy_____☐Other(specify)_____	
NOTE: This patient remains under the care of the referring physician until seen by an oncologist at OCC.	

REMINDER: Please send the following, if available:

Reports:	*Faxed*	*Pending*	Radiology Imaging:	*Faxed*	*Pending*
Referral Letter/H&P	☐	☐	Chest X-Ray	☐	☐
Operative/Brochoscopy	☐	☐	Ultrasound	☐	☐
Pathology Reports	☐	☐	Bone Scan	☐	☐
X-Ray Reports	☐	☐	CAT Scan	☐	☐
Chemo Schedules	☐	☐	MRI	☐	☐
Blood Work	☐	☐			
Pulmonary Functions	☐	☐			

send images/CD to address
Dr. Calvin Law c/o Jessica Maullon
2075 Bayview Avenue Toronto ON M4N 3M5

Sunnybrook
ODETTE CANCER CENTRE
A Cancer Care Ontario Partner

Phone Number: (416) 480-4832

We will contact the referring doctor with an appointment.

Referring Physician Signature:

_____

OCC OFFICE USE ONLY		TSRCC Reference:		SHSC Reference:	
Clinic Booked:		Date Booked:		Time Booked:	
Clinic Booked		Date Booked		Time Booked	
Clinic appointment called to:	☐ Referring Physician ☐ Hospital	☐ Patient ☐ Other (specify)		Slide Review Requested:	☐ Yes ☐ No