DIAGNOSTIC ASSESSMENT PROGRAM
HEPATO-PANCREATIC BILIARY REFERRAL FORM

Name:
Address:

Phone Number:
Other Number:
Date of Birth (MM/DD/YYYY):
Healthcard Number:
Medical Record Number (MRN):

Referral Date (MM/DD/YYYY):

Translator Required?
No Yes, please specify language:

First available HPB DAP surgeon **OR** **Dr. Wen** **Dr. Zilbert** **Dr. Garzon**

Fax: 1-877-530-4425 Main Office: 1-866-530-4464

REFERRAL INFORMATION: To be completed and signed by referring physician

Referring Physician Name:

Signature of Referring Physician (Mandatory):

Telephone Number: **Fax Number:** **Billing Number:**

Family Physician Name:

REASON FOR REFERRAL (REQUIRED)

Pancreatic Mass
Gallblader/Biliary mass
Liver Mass
Other (please indicate):

DIAGNOSTIC INFORMATION:

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

Blood Test:	Report Attached:	
LFT (INR, Bili)	Yes	No
AFP	Yes	No
CEA	Yes	No
CA19-9	Yes	No
Chronic Hepatitis Serology	Yes	No
Glucose, BUN, Creatinine, Lytes	Yes	No

Diagnostic Imaging:	Report Attached:	
CT	Yes	No
MRI	Yes	No
CXR	Yes	No
PET Scan	Yes	No
Other	Yes	No

Other Relevant Information: