

Date referral received:\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

Appointment – Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_

**FOR OFFICE USE ONLY**

**PLEASE INFORM ALL PATIENTS OF REFERRAL .TDAP WILL CONTACT PATIENT DIRECTLY WITH APPOINTMENT.**

**NOTE: An incomplete referral form may lead to delays in appointment booking.**

**FAMILY PHYSICIAN *(if not referring physician)***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRING PHYSICIAN**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAX WITH REFERRAL FORM**

[ ]  Pertinent imaging reports (i.e. chest x-ray, CT chest

 scan)

[ ]  Current List of medication

[ ]  Blood work results within last 3 months ***(including CBC, INR/PTT, Urea,***

 ***Creatinine, Electrolytes)***

[ ]  Pathology /cytology results (if available)

Current Medications list: *(if not attached)*

Significant Past Medical History *(Can attach Cumulative Patient Profile (CPP))*

Reason for Referral/Pertinent Presenting Symptoms:

***Note: CT must be ordered for all patients referred to TDAP***

CT: [ ] Completed and attached

 [ ] Ordered Date: Location of CT:

[ ] **Referral to first available physician**

 **or**

[ ] **Dr. R. Inculet** [ ] **Dr. R. Malthaner** [ ] **Dr. D. Fortin** [ ] **Dr. D. McCormack** [ ] **Dr. I. Dhaliwal**

**Is patient aware of referral?** [ ]  **Yes** [ ]  **No**

**Is the patient aware of potential cancer diagnosis?** [ ]  **Yes** [ ]  **No**

Translator required: [ ]  **Yes** [ ]  **No**

**Specify Language:**

Postal Code:

Date of referral:

Date of Birth:

Click here to enter a date.

Address:

 **TEL: (519) 685-8500 ext: 53232 FAX: (519) 432-1805**

**First name:**

**PATIENT INFORMATION**

**Last Name:**

Apt #

City, town, village

OHIP:

Phone Number:

**LUNG DIAGNOSTIC ASSESSMENT PROGRAM (TDAP) REFERRAL FORM**