

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**