south west regional cancer program

Diagnostic Assessment Program

Appendix 8

DIAGNOSTIC ASSESSMENT PROGRAM THORACIC CLINIC

URGENT REFERRAL FOR POSSIBLE LUNG CANCER

Tel: 519 376-2121 Extension 2608 Fax: 519 372-3931

Surname		Given Name	Date of Referral (dd/mm/yyyy)	
Street		City	Province	Postal Code
Home Phone ( )	Work ( )	DOB (dd/mm/yyyy)	Gender M ☐ F ☐	
OHIP Number		VC	☐ Translator Needed/Language	
Primary Contact Name		Primary Phone Number ( )	Relationship	
Referring Physician Name (print)	Physician Number	Phone ( )	Fax ( )	

Please FAX consultant notes including HISTORY OF PATIENT, BLOOD WORK and CURRENT MEDICATIONS, X-RAY, CT SCAN, PATHOLOGY/CYTOLOGY & other PERTINENT REPORTS.
Patients MUST ARRIVE ON TIME and bring with them their HEALTH CARD.

Reason for Referral: ☐ PFT's ☐ CXR Complete ☐ CT Complete

Date of Patient's Initial Consult with Referring Physician: ____________________
(dd/mm/yyyy)

Signature of Referring Physician (Mandatory) ________________________ Date: ____/____/____