Sunnybrook
ODETTE CANCER CENTRE
A Cancer Care Ontario Partner

PATIENT IDENTIFICATION

Lung Cancer Referral Form

Diagnostic Assessment Program

Phone: 416-480-5750
Fax: 416-480-7884
lung.dap@sunnybrook.ca

Referral Date (YYYY/MM/DD):_____/_____/_____

PATIENT INFORMATION

Last Name: _____ First Name: _____ DOB: _____

OHIP card: _____ Preferred Phone Number: _____

Address: _____ City/Province: _____ Postal code: _____

PHYSICIAN INFORMATION

Referring Physician: _____ OHIP billing #: _____

Bus. Tel: _____ Fax: _____

REASON FOR REFERRAL: in conjunction with abnormal imaging suggestive of or suspicious for primary lung cancer:

- ☐ A solitary pulmonary nodule or mass
- ☐ A non-peripheral pulmonary nodule or mass
- ☐ Multiple pulmonary nodules
- ☐ Mediastinal hilar adenopathy
- ☐ Hoarseness with lung mass or adenopathy
- ☐ Non-resolving pleural effusion with lung lesions
- ☐ Slowly or non-resolving pneumonia non-responsive to one cycle of antibiotics
- ☐ Pancoast tumor
- ☐ Lung mass with obvious metastatic disease
- ☐ Persistent non-massive hemoptysis
- ☐ Known lung malignancy
- ☐ Superior Vena Cava (SVC) syndrome/obstruction
- ☐ Other: _____

TESTS COMPLETED and/or ORDERED: please include x-ray/CT reports if available

- ☐ Date of suspicious chest x-ray: _____
- ☐ Other tests ordered/booked: _____

MEDICAL HISTORY AND/OR OTHER PERTINENT INFORMATION

_____

_____

_____

NOTE: THIS IS AN EXPEDITED PROGRAM

Please ensure your patient will attend the appointments to be scheduled within the month following receipt of referral.
Your patient will be contacted within 1-2 business days following receipt of referral by our nurse navigator.

Updated April 2, 2019