GRAND RIVER HOSPITAL

GRAND RIVER Regional Cancer Centre

# THORACIC DIAGNOSTIC ASSESSMENT PROGRAM REFERRAL FORM

**Please complete ALL information and include all related reports with this request and fax to**

THORACIC DAP FAX 519-749-4385 (**Phone: 519- 749-4370 Ext. 5458)**

## PATIENT'S PERSONAL INFORMATION

| | | | |
|---|---|---|---|
| NAME: | | | |
| Address | | Apt. # | City, town, village |
| Postal Code | Home phone #<br>Business/other phone # | | Permission to contact patient at this number ? |
| Date of Birth | Age | Sex: F ☐ M ☐ | Patient currently: Home ☐ Hospital ☐ Where: |

## HEALTH INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| Is patient covered under Ontario Health Insurance Plan?<br>☐ No ☐ Yes Full name on Health Card: _____ | Health Card Number | Version code | Exp date |

## REFERRAL INFORMATION: To be completed and signed by referring physician

| | | | |
|---|---|---|---|
| Referring Physician's Name: | Physician Billing #: | Tel: ( ) | Fax: ( ) |

**Signature of Referring Physician (mandatory)** _____

Family Physician Name Tel: ( ) Fax: ( )

Referral to: ☐ Respirologist ☐ Thoracic Surgeon ☐ Either

**Reason for Referral**

Date of suspicious x-ray _____/____/_____ ( Please fax x-ray report if available)
(dd/ mm/ yyyy)

| **Clinical Information** | **Please include if available:**<br>- brief history<br>- examination<br>- chest x-ray<br>- CT scan if done<br>- PFT's if available<br>- blood work |
|---|---|

| **Imaging** | **Date** | **Location** | **Date Booked** | **Location** |
|---|---|---|---|---|
| X-ray | | | | |
| Mammogram | | | | |
| CT | | | | |
| MRI | | | | |
| Nuclear Medicine | | | | |
| Ultrasound | | | | |