William Osler Health System

Division of Thoracic Surgery

Mississauga Halton Central West Regional Cancer Program
in partnership with Cancer Care Ontario

OSLER THORACIC DIAGNOSTIC ASSESSMENT PROGRAM

REFERRAL FORM

! Please fax consultant notes including history of patient, blood work, and current medications, X-ray, CT Scan, pathology/cytology and other relevant reports.
THORACIC DAP FAX: 905-458-4080 (Phone: 905-458-4521)

PATIENT'S PERSONAL INFORMATION

Name	Health Card Number	Ver.

Address	Apt. #	City, Town

Postal Code	Home Phone # Business/Other Phone #	Permission to contact patient at this #? ☐ Y ☐ N

Date of Birth (dd/mm/yyyy)	Age	Sex ☐ M ☐ F	Patient Currently: ☐ Home ☐ Hospital Other: _____

REFERRAL INFORMATION: To be completed and signed by referring physician

Referring Physician Name:	**Signature of Referring Physician (mandatory):**	
Physician Billing #:	Tel: ( )	Fax: ( )
Family Physician Name:	Tel: ( )	Fax: ( )

REASON FOR REFERRAL:

- ☐ **Suspicion for lung cancer**
- ☐ **Suspicion for esophageal cancer**
- ☐ **Other (eg. mediastinal disease):**_____

NOTES

***If CT not arranged, please indicate all that apply:**

- ☐ Renal insufficiency
- ☐ Diabetic On Metformin? ☐ Y ☐ N
- ☐ Serum Creatinine (Within 28d, please attach)
- ☐ Allergic to contrast
- ☐ On anticoagulant Medication: _____

Internal Use Only

Date received: _____ / Date pt. contacted: _____ / Staff initial: _____