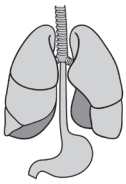
Reset Form

Trillium Health Partners

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



TRILLIUM HEALTH PARTNERS
THORACIC DIAGNOSTIC ASSESSMENT PROGRAM
REFERRAL FORM

! Please fax consult notes including history of patient, blood work, current medications, X-ray, CT Scan, pathology/cytology and other relevant reports (if completed).
THORACIC DAP FAX: 1-877-530-4425 | PHONE: 1-866-530-4464

Patient Information (AFFIX PATIENT LABEL)	REFERRING PHYSICIAN INFORMATION (STAMP)
Last Name:	Referring Physician Name:
First Name:	Speciality: ☐ GI ☐ General Surgery ☐ Primary Care ☐ Emergency ☐ Other: _____
Health Card #: V.C.:	
Date of Birth:	Address:
Address:	Phone:
City:	Fax:
Province: Postal Code:	Billing #:
Phone #1:	Family Physician name:
Phone #2:	***Referring Physician Signature:***
Phone #3:	

REASON FOR REFERRAL

- ☐ Suspicion for lung cancer
- ☐ Suspicion for esophageal cancer
- ☐ Other (eg. mediastinal disease): _____
- ☐ Thoracic Surgery at Trillium Health Partners, Credit Valley Hospital
- ☐ Respirology at ☐ Halton Healthcare (Oakville) or ☐ Trillium Health Partners (Mississauga Hospital)

NOTES:

Has CT been ordered? ☐ **Y** ☐ **N** **Location:** _____

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

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

INTERNAL USE ONLY

Date Received: _____ Date patient contacted: _____ Staff initial: _____

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