SOUTHLAKE
REGIONAL HEALTH CENTRE

56 Prospect Street
Newmarket, ON L3Y 3S9

Diagnostic Assessment Unit

Health Record #: ____________ Complete or place patient label here
Patient Name: *(Print first, last)* ____________
DOB: mm / dd / yy Age: ______ ❑ Female ❑ Male
OHIP #: ____________ Version Code: ____________
Account #: ____________ Date of Admission: mm / dd / yy

Lung Program – Physician Referral

Please fax to: 1-877-62-CHEST (24378)

Patient Address:

Patient Phone Number: | **Patient Alternate Phone Number:**

Primary Care Physician Name: *(if different from referring Physician) (print first, last)*

REASON FOR REFERRAL:

❑ **Abnormal Imaging:** ❑ **SRHC:** ❑ Chest Xray ❑ Other: ____________
❑ **Outside:** reports must be attached ____________

❑ **Concerning Symptoms:** ____________

❑ **Other:** ____________

Details: ____________

SIGNIFICANT MEDICAL HISTORY:

____

MEDICATIONS: ❑ Anticoagulants ❑ Antiplatelets ❑ ASA/NSAIDS ❑ Bronchodilators

Others: ____________

Comments: ____________

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL

Referring Physician Name: *(print first, last)*	**Billing #:**
Referring Physician Signature:	**Date:** mm / dd / yy
Phone Number:	**Fax Number:**

CLINIC USE ONLY	
Date referral received: mm / dd / yy	**APPOINTMENT – Date:** mm / dd / yy **Time:** ______

SL1697_05 (01/13) "Diagnostic Assessment Unit" Review (01/16)