



**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: <input type="checkbox"/> GI <input type="checkbox"/> General Surgery	
Health Card #: _____ V.C.: _____		<input type="checkbox"/> Primary Care <input type="checkbox"/> Emergency	
Date of Birth:		<input type="checkbox"/> Other: _____	
Address:		Address:	
City:		Phone:	
Province: _____ Postal Code: _____		Fax:	
Phone #1:		Billing #:	
Phone #2:		Family Physician name:	
Phone #3:		Referring Physician Signature:	

REASON FOR REFERRAL

Suspicion for lung cancer

Suspicion for esophageal cancer

Other (eg. mediastinal disease): _____

Thoracic Surgery at Trillium Health Partners, Credit Valley Hospital

Respiriology 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**

<input type="checkbox"/> Renal insufficiency	<input type="checkbox"/> Allergic to contrast
<input type="checkbox"/> Diabetic On Metformin? <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> On anticoagulant Medication: _____
<input type="checkbox"/> Serum Creatinine (Within 28d, please attach)	

INTERNAL USE ONLY

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

