

REGIONAL LUNG DIAGNOSTIC ASSESSMENT PROGRAM (Lung DAP)

Outpatient clinic for patients with a suspicion of Lung Cancer

Tel: 1-877-801-4822 / 905-521-6190

Fax: 1-877-803-4422 / 905-540-6581

Surname:		Given Name:		Date of Referral (DD/MM/YYYY):	
Street:			City:	Province:	Postal Code:
Contact Number:		Work Phone:		Date of Birth (DD/MM/YYYY):	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other__
OHIP Number:			VC:	Translator Required: <input type="checkbox"/> Yes <input type="checkbox"/> No Language (please specify): _____	
Name of Primary Contact:		Phone Number:		Relationship:	

Additional / Relevant Information:

REPORTS MUST BE ATTACHED

Suspicion of Lung Cancer due to results of:

<input type="checkbox"/> X-ray	Date:	Location:
<input type="checkbox"/> CT scan	Date:	Location:
If CT not completed state:	Date Ordered:	Location:
<input type="checkbox"/> MRI Chest	Date:	Location:

Please attach the following

Past Medical History /CPP List of current medications Report with recent CBC, Creat, INR, PTT (if available)

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

Patient must be ready to proceed with appointments and diagnostic tests at the time of referral.

Referring Physician (print first, last):		Billing #:
Referring Physician Signature:		Date (DD/MM/YYYY):
Phone Number:	Fax Number:	

Please ensure referral is complete. Incomplete forms will be returned.



ONCOLOGY CLINIC
519-751-5544 ext. 5585

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St. Joseph's
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