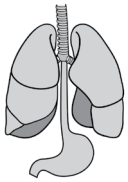
Trillium Health Partners

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)

Last Name:

First Name:

Health Card Number:

Version Code:

Date of Birth:

Address:

City:

Province: Postal Code:

Phone Number 1:

Phone Number 2:

Phone Number 3:

REFERRING PHYSICIAN INFORMATION (STAMP)

Referring Physician Name:

Speciality: ☐ Gastrointestinal ☐ General Surgery ☐ Primary Care ☐ Emergency

☐ Other:

Address:

Phone Number: Fax Number: Billing Number:

Family Physician name:

Referring Physician Signature:

REASON FOR REFERRAL

☐ Suspicion for lung cancer

☐ Suspicion for esophageal cancer

☐ Thoracic Surgery at Trillium Health Partners, Credit Valley Hospital

☐ Respirology at ☐ Halton Healthcare (Oakville) or ☐ Trillium Health Partners (Mississauga Hospital)

☐ Other (eg. mediastinal disease):

NOTES:

Has CT been ordered? ☐ Yes ☐ No **Location:**

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

☐ **Renal insufficiency**

☐ **Diabetic** **On Metformin?** ☐ **Yes** ☐ **No**

☐ **Serum Creatinine** **(Within 28 days, please attach)**

☐ **Allergic to contrast**

☐ **On anticoagulant** **Medication:**

INTERNAL USE ONLY

Date Received(MM/DD/YYYY): Date patient contacted(MM/DD/YYYY): Staff initial: