mississauga halton /central west regional cancer program
in partnership with cancer care ontario

William Osler Health System

Division of Thoracic Surgery

THORACIC DIAGNOSTIC ASSESSMENT PROGRAM

REFERRAL FORM

All referrals will be booked within 72 hours

! Please fax consultant notes including history of patient, blood work, and current medications, X-ray, CT Scan, pathology/cytology and other relevant reports.
THORACIC DAP FAX: 905-458-4080 (Phone: 905-458-4520)

PATIENT'S PERSONAL INFORMATION

Name	Health Card Number	Ver.

Address	Apt. #	City, Town

Postal Code	Home Phone # Business/Other Phone #	Permission to contact patient at this #? ☐ Y ☐ N

Date of Birth (dd/mm/yyyy)	Age	Sex ☐ M ☐ F	Patient Currently: ☐ Home ☐ Hospital Other: _____

REFERRAL INFORMATION: To be completed and signed by referring physician

Referring Physician Name:	**Signature of Referring Physician (mandatory):**	
Physician Billing #:	Tel: ( )	Fax: ( )
Family Physician Name:	Tel: ( )	Fax: ( )

REASON FOR REFERRAL:
- ☐ **Suspicion for lung cancer**
- ☐ **Suspicion for esophageal cancer**
- ☐ **Other (eg. mediastinal disease):**_____

NOTES

***If CT not arranged, please indicate all that apply:**
- ☐ Renal insufficiency
- ☐ Diabetic On Metformin? ☐ Y ☐ N
- ☐ Serum Creatinine (Within 28d, please attach)
- ☐ Allergic to contrast
- ☐ On anticoagulant Medication: _____

Internal Use Only

Date received: _____ / Date pt. contacted: _____ / Staff initial: _____

www.williamoslerhs.ca/thoracic-surgery