THORACIC ASSESSMENT CLINIC

URGENT REFERRAL FOR POSSIBLE LUNG CANCER

Tel: 519 376-2121 ext.2608 Trudy Morrison RN. Nurse Navigator Fax: 519 372-3931

Surname		Given Name	Date of Referral (dd/mm/yyyy)	
Street		City	Province	Postal Code
Home Phone ( )	Work ( )	DOB (dd/mm/yyyy)	Gender M ☐ F ☐	
OHIP Number		VC	Email address	
Referring Physician Name (print)	Physician Number	Phone ( )	Fax ( )	

Reason for Referral

- ☐ Suspected Thoracic malignancy
- ☐ Pleural effusion NYD
- ☐ Hemoptysis
- ☐ Patients referred to radiology for Percutaneous lung biopsy

- ☐ CT chest completed and results attached
- ☐ CT chest pending: date and location ordered
- ☐ Chest x-ray
- ☐ Blood work: date and location *Current CBC, INR/PTT (very helpful)
- ☐ Pulmonary Function test: date and location

Medical history: Comorbidities, Medications and allergies

Signature of Referring Physician (Mandatory) _____ Date: _____

- ❖ by signing this form: you acknowledge the patient is aware of the referral to the lung diagnostic assessment program and potential cancer diagnosis