THORACIC ONCOLOGY COLLABORATIVE PROGRAM

Fax: 1-844-467-2204
Tel: 1-866-338-1778 Ext. 6333

Preferred Assessment Center	❑ Lakeridge Health Oshawa	❑ Scarborough and Rouge Hospital, Centenary site	❑ Michael Garron Hospital
Patient Last Name:	First Name:		Gender Male ❑ Female ❑
Address:	City	Postal Code	OHIP #
Birth date (dd/mm/yyyy)	Home Phone#		Other phone #

Is Patient is aware of referral?
Yes ❑ No ❑

Referring Physician	Address	Phone # Fax #
Family Physician (if not referring physician)	Address	Phone # Fax #
Signature of referring physician	Billing number	Date (dd/mm/yyyy)

Select reason for referral

❑ **Imaging/Results Suspicious of Cancer: Check all that apply**	**Clinical Symptoms suspicious of Cancer. Please describe**
❑ Chest Xray ❑ CT of chest ❑ MRI ❑ Pathology/Cytology ❑ Endoscopy findings Other:	❑ ❑ ❑ ❑ ❑ Other:

Test completed	**Date**	**Location**
CT of chest		
Chest X-Ray		
MRI		
Pathology/Cytology		
Nuclear Medicine		

Additional clinical information:

For Office use:

Appointment Date and Time	Physician	Location