Central East Thoracic Clinic & Diagnostic Assessment Program

Fax: 1-877-291-5956

Tel: 1-866-338-1778 Ex. 4503

Date of Referral: _____ (dd/mm/yyyy) ❑ Patient has been informed of this referral

The Thoracic Clinic and DAP will provide patients in the Central East LHIN with timely access to an interdisciplinary team. Members of the team include: thoracic surgeon, radiologist, pathologist, nurse navigator (RN) and other health disciplines. The Nurse Navigator will facilitate the plan of care.

Referring Physician	**Family Physician (if differs from referring MD):**
Name: _____	Name:
Phone: _____ Fax:_____	_____
Physician Signature: _____	Phone:_____
Physician Billing Number: _____	Fax:_____

Patient Information (name as it appears on Health Card)

HCN# _____ VC ____ Unique# _____

Surname: _____ Given Name: _____ Initial: _____

Address: _____ Town: _____

Postal Code: _____ Home Phone: _____ Work: _____

Contact: _____ Date of Birth: _____

Specify Preferred Assessment Centre: ❑ Oshawa ❑ Peterborough ❑ Scarborough ❑ 1st available

Reason for Referral: ❑ Known malignancy ❑ Suspicious for malignancy ❑ Benign

❑ Pleural Effusion suspicious for malignancy **(Malignant Pleural Effusion Clinic Oshawa location only)**

Clinical Information:

Tests Completed/Pending	Date	Location
X-ray		
CT		
MRI		
Nuclear Medicine		
Pathology		
Other: _____		

Thoracic Clinic Use Only

Priority 1 2 3 4

Appointment Date and Time: _____ NN Signature_____

Apt type: _____ MD Resource:_____