Lakeridge Health | NHH Northumberland Hills Hospital | PRHC Peterborough Regional Health Centre | Central East Regional Cancer Program, Ontario Health (Cancer Care Ontario)

Central East Thoracic Diagnostic Assessment Program

Fax: 1−877−291−5956

Tel: 1−866−338−1778 Ex. 32169

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

The Thoracic DAP will provide patients in the Central East with timely access and support of an interdisciplinary team. The Nurse Navigator (RN) in collaboration with Thoracic Surgeon and other health disciplines will facilitate the plan of care.

Referring Physician
Name: _____
Phone: _____ Fax: _____
Physician Signature: _____
Physician Billing Number: _____

Primary Care Provider (if differs from referring)
Name:
_____
Phone: _____
Fax: _____

Patient Information (name as it appears on Health Card)
HCN# _____ VC _____
Surname: _____ Given Name: _____ Initial: _____
Address: _____ Town: _____
Postal Code: _____ Home Phone: _____ Work: _____
Contact: _____ Date of Birth: _____

Specify Preferred Location: ❒ Oshawa ❒ Peterborough ❒ Cobourg ❒ 1st available

Reason for Referral: ❒ Known malignancy ❒ Suspicious for malignancy ❒ Benign
❒ Malignant Pleural Effusion (MPE) for effusion due to malignancy **(Oshawa location only)**

Clinical Information:

Tests Completed/Pending	Date	Location
X−ray		
CT		
MRI		
Nuclear Medicine		
Pathology		
PFT		
Cardiac Investigation		
Other:		

Thoracic Clinic Use Only

Priority 1 2 3 4

Appointment Date and Time: _____ **NN Signature** _____