Waterloo Wellington Regional Cancer Program
in partnership with Cancer Care Ontario

LUNG DIAGNOSTIC ASSESSMENT PROGRAM REFERRAL FORM

NOTE: For an inpatient or urgent consult
please call St. Mary's General Hospital (519-744-3311)
and ask to speak to the respirologist on call, as these are not appropriate for this program

Please complete ALL information and include all related reports with this request and fax to
LUNG DAP FAX: 519-749-4384 (**Phone: 519-749-4370 Ext. 5458)**

PATIENT'S PERSONAL INFORMATION

Name:			
Address		Apt. #	City, Town, Village
Postal Code	Home phone #		Permission to contact patient at this #? ☐ Yes ☐ No
Date of Birth	Age	Sex: F ☐ M ☐	

HEALTH INSURANCE INFORMATION

Is patient covered under Ontario Health Insurance Plan? No ☐ Yes ☐ Name on health card: _____	Health Card Number	Version code	Exp date

REFERRAL INFORMATION: To be completed and signed by referring physician

Referring Physician's Name:	Physician Billing #:	Tel: ( )	Fax: ( )

*** Signature of Referring Physician (mandatory)**

Family Physician Name Tel: ( ) Fax: ( )

Reason for Referral

Please note – biopsies are NOT done on the first visit

A CT chest is required for the specialist consult. Please comment below if you have ordered a CT chest – include date and location (The DAP team will attempt to expedite the appointment if necessary)

☐ **Abnormal CT Chest - Date of suspicious CT** _____/____/_____ **(included CT report)**
(dd mm yyyy)

☐ **CT Chest ordered on** _____/____/_____ **at** _____**(hospital location)**
(dd mm yyyy)

☐ **Abnormal Chest X-ray** - Date of suspicious x-ray _____/____/_____ **(include x-ray report)**
(dd mm yyyy)

If Diagnostic Assessment Program team assistance required for arranging CT chest – Please indicate all that apply ;

☐ Blood work included with creatinine
☐ Allergic to contrast ☐ Diabetic ☐ Taking Metformin ☐ On blood thinner

Clinical Information: (brief history, updated medication list, PFT's and blood work if available)

Previous Tests and Consultations

Other Tests	Date	Location

Has the patient had a previous visit with a respirologist? ☐ Yes ☐ No **Name:**