GRAND RIVER
Regional Cancer Centre

Malignant Pleural Effusion (MPE) Clinic

REFERRAL FORM

Please fax the completed referral form to 519-749-4384

Please instruct patient to stop all oral anticoagulants 5 days before procedure, subcutaneous anticoagulants 24 hours before procedure and Plavix 7 days before procedure (if any concerns please call GRH Respirologist on call).

Please note that an incomplete referral may result in treatment delay

Date _____ Patient Phone Number _____

MRN Number _____

Patient Name _____ Date of Birth _____

Referring Physician _____

Attending Oncologist(s) _____

Palliative Care MD/Nurse _____

Primary cancer site (please √) ☐ lung ☐ breast ☐ ovarian ☐ other (specify) _____

Date of diagnosis _____

Site of metastases (please √) ☐ bone ☐ brain ☐ liver ☐ bone marrow
☐ lung ☐ other (specify) _____

Date of last CXR _____

Previous thoracentesis ☐ Yes ☐ No Date of last thoracentesis _____

Current chemo Type _____ Date of last treatment _____

Previous lung radiation ☐ Yes ☐ No Date of treatment _____

Previous surgery Site _____ Date _____

Medications:

Medication/Dose/Frequency	Medication/Dose/Frequency	Medication/Dose/Frequency

Other relevant medical history:

_____

_____

Referral to: - Palliative Care Clinic ☐ completed
- ESAS & PPS ☐ completed & attached (GRH internal)

Signature of referring physician _____ Date_____

For inquiries please call 519-749-4300 x5458