Lung Diagnostic Assessment Program Referral Form

Waterloo Wellington Regional Cancer Program
in partnership with Cancer Care Ontario

Please note:

- For an inpatient or urgent consult, please contact the respirologist on call at Grand River Hospital (519-749-4300).
- A CT chest is **required** for the specialist consult.
- Biopsies are **not** done on the first visit.

Referral Date:

YYYY MM DD

Patient Information (please print)		**Referring Physician Information** (please print)
Health Card Number:	Preferred Language: ☐ English ☐ Other:	Name:
VC:	Restricted Mobility: ☐ Yes ☐ No	Phone:
Last Name:	First Name:	Fax:
DOB: YYYY MM DD	Sex: ☐ Male ☐ Female	Street Address:
Street Address:	City/Town:	City/Town:
Province:	Postal Code:	Email:
Phone (home):	Patient consents to leave message: ☐ Yes ☐ No	Billing Number:
Phone (cell):	Patient consents to leave message: ☐ Yes ☐ No	Signature:
Email:	Patient consents to receive information by email: ☐ Yes ☐ No	

Medical History

A CT chest is **required** for the specialist consult.

Abnormal CT chest: Date of suspicious CT _____ (include CT report)
YYYY MM DD

Abnormal chest x-ray: Date of suspicious x-ray _____ (include x-ray report)
YYYY MM DD

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, PFTs and blood work, if available:

Previous Tests and Consultations:

Test	Date	Location

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

Please send completed referral and all related reports to:

Fax: (519) 749-4384

Phone: (519) 749-4300 ext. 5458