LUNG DIAGNOSTIC
ASSESSMENT PROGRAM (DAP)

REFERRAL FORM

Telephone: (807) 345-4337
Fax: (807) 345-4319

Place label here

PATIENT INFORMATION	REFERRING PROVIDER INFORMATION (Please Print)
Last Name	Name
Given Name(s)	Telephone
Date of Birth _____ / _____ / _____ (Day / Month / Year)	Fax Number
Gender ☐ Male ☐ Female	Date of Referral
Home Telephone Cell	☐Translator Needed /Language:
Work Telephone	Physician Signature (**Mandatory**)
Address	
Health Card Number Version	

REASON FOR REFERRAL TO LUNG DAP:

☐ Chest X-ray Suspicious of Lung Cancer
☐ Chest Computed Tomography (CT) Suspicious of Lung Cancer **(NODULE ≥ 8mm)**
☐ Pneumonia Non Responsive to Antibiotics in 6 Weeks
☐ Hemoptysis
☐ Clinical Symptoms Suspicious of Lung Cancer

CLINICAL INFORMATION:

PATIENTS WILL NOT BE SEEN WITHOUT THE FOLLOWING REQUIREMENTS:

Recent CT scan within 6 weeks, Patient History & Blood Work

Please FAX notes including:

PATIENT HISTORY & CURRENT MEDICATIONS
BLOOD WORK (Complete Blood Count (CBC), Lytes, Liver Enzymes, HCO3, AST, BUN, Ionized Calcium, PTT, INR)
X-RAY & CT SCAN REPORTS
PATHOLOGY, CYTOLOGY & other pertinent REPORTS.

LUNG DAP WILL CONTACT PATIENT WITH APPOINTMENT

FCS- 289 Approved Jan 2011 Rev. Feb 11 Rev. Aug 14 Rev. June 15

GUIDELINES for Completion:

1. **Please complete DAP referral form and fax to 807-345-4319.**
2. **Primary Care Provider must sign form.**
3. **Referral form will be filed with patient's record in Dr. Gehman's office.**
4. **If further Diagnostic Imaging testing is required, a copy of the referral will be sent to Diagnostic Imaging and stored with the patient's images in PACs.**