Thunder Bay Regional Health Sciences Centre

THORACIC DIAGNOSTIC ASSESSMENT PROGRAM (TDAP)

# REFERRAL FORM

Place Label Here

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

| **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 Computed Tomography (CT) Suspicious of Lung Cancer
**(NODULE ≥ 1cm) and/or ( Lung Mass > 3cm) and/or (Mediastinal Adenopathy > 2cm)**
☐ Signs of Superior Vena Cava Syndrome (facial and/or upper trunk edema)
☐ Pleural Effusion with Nodule, Adenopathy or Pleural Thickening
☐ Ontario Lung Screening Program (OLSP)
****Please note: patients require a completed CT scan prior to consult****

**CLINICAL INFORMATION:**

**PATIENTS WILL NOT BE SEEN WITHOUT THE FOLLOWING REQUIREMENTS:**

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

Please **FAX (807) 345-4319** notes including:
**PATIENT HISTORY & CURRENT MEDICATIONS**
**BLOOD WORK (Complete Blood Count (CBC), Creatinine, INR, PTT) & CT SCAN REPORTS**
**PATHOLOGY, CYTOLOGY & other pertinent REPORTS.**

**THORACIC DAP WILL CONTACT PATIENT WITH APPOINTMENT**

**GUIDELINES for Completion (EMERGENCY DEPARTMENT use ONLY):**

1. **Please complete TDAP referral form and fax with included documents to 807-345-4319.**
2. **Emergency Department Physician must sign form.**
3. **Referral form will be filed with patient's record in Dr. Sun's office.**