GRAND RIVER HOSPITAL

GRAND RIVER Regional Cancer Centre

THORACIC DIAGNOSTIC ASSESSMENT UNIT REFERRAL FORM

Please complete ALL information and include all related reports with this request and

THORACIC DAU FAX 519-749-4385 (**Phone: 519- 749-4370 Ext. 5458)**

PATIENT'S PERSONAL INFORMATION

NAME:			
Address		Apt. #	City, town, village
Postal Code	Home phone # Business/other phone #		Permission to contact patient at this number ?
Date of Birth	Age	Sex: F ☐ M ☐	Patient currently: Home ☐ Hospital ☐ Where:

HEALTH INSURANCE INFORMATION

Is patient covered under Ontario Health Insurance Plan? ☐ No ☐ Yes Full 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: ( )

Referral to: ☐ Respirologist ☐ Thoracic Surgeon ☐ Either

Reason for Referral

Date of suspicious x-ray _____/____/_____ (Please fax x-ray report if available)
(dd/ mm/ yyyy)

Clinical Information	**Please include if available:** - brief history - examination - chest x-ray - CT scan if done - PFT's if available - blood work

Imaging	**Date**	**Location**	**Date Booked**	**Location**
X-ray				
Mammogram				
CT				
MRI				
Nuclear Medicine				
Ultrasound				