waterloo wellington regional cancer program
in partnership with cancer care ontario

GRAND RIVER HOSPITAL

THORACIC DIAGNOSTIC ASSESSMENT PROGRAM REFERRAL FORM

Please complete ALL information and include all related reports with this request and fax to
THORACIC DAP FAX: 519-749-4384 (**Phone: 519- 749-4370 Ext. 5458)**

PATIENT'S PERSONAL INFORMATION

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

HEALTH INSURANCE INFORMATION

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

Reason for Referral

NOTE:
A CT chest is required for the specialist consult. Please comment below if you have ordered a CT chest – include date and location (The DAP team will attempt to expedite the appointment if necessary)

☐ **Abnormal CT Chest - Date of suspicious CT _____/____/_____ (CT report included with referral)**
(dd/ mm/ yyyyy)

☐ **CT Chest ordered on _____/____/_____ at _____(hospital location)**
dd mm yyyy

☐ **Abnormal Chest X-ray** - Date of suspicious x-ray _____/____/_____ (include x-ray report)
(dd/ mm / yyyyy)

**** If Diagnostic Assessment Program team assistance required for arranging CT chest, please contact us directly by phone***

Clinical Information: (brief history, examination, PFT's and blood work if available)

Has the patient had a previous visit with a respirologist? ☐ Yes ☐ No
Details of consultation :

Test	Date	Location	Date Booked	Location