REGIONAL LUNG DIAGNOSTIC ASSESSMENT PROGRAM (Lung DAP)

Outpatient clinic for patients with a suspicion of Lung Cancer

FAX: 519 751-5839 **Tel:** 519 751-5544 ext 4255

Surname:	Given Name:	Date of Referral (DD/MM/YYYY):	
Street:	City:	Province:	Postal Code:
Contact Number:	Work Phone:	Date of Birth (DD/MM/YYYY):	Gender: D M D F D Other___
OHIP Number:	VC:	Translator Required: D Yes D No Language (please specify): _____	
Name of Primary Contact:	Phone Number:	Relationship:	

Additional / Relevant Information:

REPORTS MUST BE ATTACHED

Suspicion of Lung Cancer due to results of:

D X-ray	Date:	Location:
D CT scan	Date:	Location:
If CT not completed state:	Date Ordered:	Location:
D MRI Chest	Date:	Location:

Please attach the following

D Past Medical History /CPP D List of current medications D Report with recent CBC, Creat, INR, PTT (if available)

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF REFERRAL.

Patient must be ready to proceed with appointments and diagnostic tests at the time of referral.

Referring Physician (print first, last):	Billing #:
Referring Physician Signature:	Date (DD/MM/YYYY):
Phone Number:	Fax Number:

Please ensure referral is complete. Incomplete forms will be returned.

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St. Joseph's Healthcare Hamilton