SOUTHLAKE
REGIONAL HEALTH CENTRE

56 Prospect Street
Newmarket, ON L3Y 359

Diagnostic Assessment Unit

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* _____
DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: dd / mm / yy

Lung Program – Physician Referral

Please fax to: 1-877-62-CHEST (24378)

Patient Address:

Patient Phone Number: | **Patient Alternate Phone Number:**

Primary Care Physician Name: *(if different from referring Physician) (print first, last)*

REASON FOR REFERRAL:

❑ **Abnormal Imaging:** ❑ **SRHC:** ❑ Chest Xray ❑ Other: _____
❑ **Outside:** reports must be attached _____

❑ **Concerning Symptoms:** _____

❑ **Other:** _____

Details: _____

_____

_____

_____

SIGNIFICANT MEDICAL HISTORY:

_____

_____

_____

MEDICATIONS: ❑ Anticoagulants ❑ Antiplatelets ❑ ASA/NSAIDS ❑ Bronchodilators

Others: _____

_____

Comments: _____

_____

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

Referring Physician Name: *(print first, last)* | **Billing #:**

Referring Physician Signature: | **Date:** dd / mm / yy

Phone Number: | **Fax Number:**

CLINIC USE ONLY

Date referral received: dd / mm / yy | **APPOINTMENT – Date:** dd / mm / yy **Time:** _____

S-DIAAULPHR