York Thoracic Surgery

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THORACIC REFERRAL FORM
Diagnostic Assessment Program

Referral Date (YYYY/MM/DD) ________/________/________

PATIENT INFORMATION
Surname ______________________ First Name ______________________ DOB __________ Gender ________

OHIP/HIN # ______________________ Preferred Phone # ______________________

Street Address ______________________ City ______________________ Postal Code __________

Patient Location ☐Home ☐Hospital ______________________

REASON FOR REFERRAL

- ☐ Diagnostic Imaging Suspicious of Lung Cancer
- ☐ Peripheral nodule or mass in smoker
- ☐ Non-peripheral mass or nodule in smoker
- ☐ Nodule or mass in non-smoker
- ☐ Multiple pulmonary nodules
- ☐ Pleural effusion
- ☐ Mediastinal or hilar adenopathy
- ☐ Slowly or non-resolving pneumonia
- ☐ Other: ______________________

- ☐ Clinical Symptoms Suspicious of Lung
- ☐ Massive hemoptysis
- ☐ Non-Massive hemoptysis
- ☐ Superior Vena Cava Syndrome (SVC)
- ☐ Stridor

PLEASE ATTACH CREATININE RESULTS NO OLDER THAN 90 DAYS

URGENCY: ☐Emergent (<72 hrs – please call YTSA) ☐Urgent (<2weeks)

PLEASE INCLUDE ALL INFORMATION PERTINENT TO REFFERAL
(consults, imaging reports, Bone Scan, PFT, Echocardiogram, recent blood work etc.)

Date of suspicious CXR/CT scan ______/________/________ in clinic / hospital ______________________

Other tests ordered/booked ______________________

Relevant Medical History ______________________

____

REFERRING PHYSICIAN ______________________

Billing # ______________ Phone ______________ Fax ______________

FAMILY PHYSICIAN ______________________

Billing # ______________ Phone ______________ Fax ______________

Preferred Location of Consultation
Patient to be seen at: ☐ Newmarket ☐ Barrie ☐ OSMH (Orillia) ☐HHCC (Orangeville) ☐SMH (Alliston) ☐ SRCC

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