SOUTHLAKE
REGIONAL HEALTH CENTRE

581 Davis Drive, Medical Arts Buliding
Newmarket, ON L3Y 359

Diagnostic Assessment Unit

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

Lung Program – Physician Referral

Please fax referral to identified physican below:

Patient Address:	❑ **Dr. Julius Toth: 1-877-622-4378**
Patient Phone Number(s):	❑ **Dr. Salvatore Privitera: 1-877-622-4378**
Primary Care Physician Name:	❑ **Dr. Crystal Kavanagh: 905-967-9788**

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:** _____