



Leading Edge Care. Close to Home.

581 Davis Drive, Medical Arts Building
Newmarket, ON L3Y 3S9

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 referral to identified physician below:

- Division of Thoracic Surgery: 905-954-4133
- Dr. Julius Toth: 1-877-622-4378
- Dr. Salvatore Privitera: 1-877-622-4378
- Dr. Nader Hanna: 905-954-4133

Patient Address: _____

Patient Phone Number(s): _____

Primary Care Physician Name: _____

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