

**Medical Arts Building**

581 Davis Drive, Suite 384, Newmarket, ON L3Y 2P6  
905-895-4521 ext. 5274

Division of Thoracic Surgery

|                                                |                                                                          |
|------------------------------------------------|--------------------------------------------------------------------------|
| Health Record #: _____                         | Complete or place barcoded patient label here                            |
| Patient Name: <i>(Print first, last)</i> _____ |                                                                          |
| DOB: <u>dd</u> / <u>mm</u> / <u>yy</u>         | Age: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male |
| OHIP #: _____                                  | Version Code: _____                                                      |
| Account #: _____                               | Date of Admission: <u>dd</u> / <u>mm</u> / <u>yy</u>                     |

## Thoracic Referral Form

**Please fax to (905) 952-3564**

|                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                 |                                                                                                                                                                                                                                                    |                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> <b>First Available</b><br><input type="checkbox"/> <b>Dr. Julius L. Toth</b> , MD, MSc, FRCSC, FACS, FCCP<br><input type="checkbox"/> <b>Dr. Salvatore Privitera</b> , MD, MSc, FRCSC<br><input type="checkbox"/> <b>Dr. Nader M. Hanna</b> , MBBS, MSc, FRCSC |                                                                                                                                                                                 | <b>Preferred Location of Consultation:</b><br>Patient to be seen at:<br><input type="checkbox"/> Newmarket <input type="checkbox"/> Barrie <input type="checkbox"/> Orillia <input type="checkbox"/> Orangeville <input type="checkbox"/> Alliston |                                         |
| <b>Referral Date</b> (dd/mm/yy) <u>dd</u> / <u>mm</u> / <u>yy</u>                                                                                                                                                                                                                       |                                                                                                                                                                                 |                                                                                                                                                                                                                                                    |                                         |
| <b>PATIENT INFORMATION</b>                                                                                                                                                                                                                                                              |                                                                                                                                                                                 |                                                                                                                                                                                                                                                    |                                         |
| Patient Name: <i>(print first, last)</i> _____                                                                                                                                                                                                                                          |                                                                                                                                                                                 | Date of Birth: <u>dd</u> / <u>mm</u> / <u>yy</u>                                                                                                                                                                                                   | Gender: _____                           |
| OHIP/HIN # _____                                                                                                                                                                                                                                                                        |                                                                                                                                                                                 | Patient Phone Number(s): _____                                                                                                                                                                                                                     |                                         |
| Address: _____                                                                                                                                                                                                                                                                          |                                                                                                                                                                                 |                                                                                                                                                                                                                                                    |                                         |
| Patient Location: <input type="checkbox"/> Home <input type="checkbox"/> Hospital <i>Name of Hospital:</i> _____                                                                                                                                                                        |                                                                                                                                                                                 |                                                                                                                                                                                                                                                    |                                         |
| <b>REASON FOR REFERRAL</b>                                                                                                                                                                                                                                                              |                                                                                                                                                                                 |                                                                                                                                                                                                                                                    |                                         |
| <input type="checkbox"/> Diagnostic Imaging Suspicious of Lung Cancer<br><input type="checkbox"/> Lung Nodule<br><input type="checkbox"/> Pleural effusion<br><input type="checkbox"/> Mediastinal or hilar adenopathy                                                                  | <input type="checkbox"/> Hemoptysis<br><input type="checkbox"/> Stridor<br><input type="checkbox"/> Benign lung finding on imaging<br><input type="checkbox"/> Mediastinal Mass | <input type="checkbox"/> Hiatal Hernia / GERD<br><input type="checkbox"/> Esophageal Cancer<br><input type="checkbox"/> Other                                                                                                                      |                                         |
| URGENCY <input type="checkbox"/> Emergent (<72 hrs - page on call surgeon) <input type="checkbox"/> Urgent (<2 weeks) <input type="checkbox"/> Non-Urgent (>2 weeks)                                                                                                                    |                                                                                                                                                                                 |                                                                                                                                                                                                                                                    |                                         |
| <b><u>PLEASE INCLUDE ALL INFORMATION PERTINENT TO REFERRAL</u></b><br>(consults, imaging reports, Bone Scan, PFT, Echocardiogram, recent blood work etc.)                                                                                                                               |                                                                                                                                                                                 |                                                                                                                                                                                                                                                    |                                         |
| Date of suspicious CXR/CT scan <u>dd</u> / <u>mm</u> / <u>yy</u> in clinic/hospital                                                                                                                                                                                                     |                                                                                                                                                                                 |                                                                                                                                                                                                                                                    |                                         |
| Other tests ordered/booked: _____                                                                                                                                                                                                                                                       |                                                                                                                                                                                 |                                                                                                                                                                                                                                                    |                                         |
| Relevant Medical History: _____                                                                                                                                                                                                                                                         |                                                                                                                                                                                 |                                                                                                                                                                                                                                                    |                                         |
| <b>Referring Physician Name:</b> <i>(print first, last)</i> _____                                                                                                                                                                                                                       |                                                                                                                                                                                 | Billing #: _____                                                                                                                                                                                                                                   |                                         |
| Phone #: _____                                                                                                                                                                                                                                                                          | Fax #: _____                                                                                                                                                                    | Signature: _____                                                                                                                                                                                                                                   | Date: <u>dd</u> / <u>mm</u> / <u>yy</u> |
| <b>Family Physician Name:</b> <i>(print first, last)</i> _____                                                                                                                                                                                                                          |                                                                                                                                                                                 | Billing #: _____                                                                                                                                                                                                                                   |                                         |
| Phone #: _____                                                                                                                                                                                                                                                                          | Fax #: _____                                                                                                                                                                    | Signature: _____                                                                                                                                                                                                                                   | Date: <u>dd</u> / <u>mm</u> / <u>yy</u> |

