St. Joseph's Healthcare Hamilton Lung Diagnostic Assessment Program (Lung DAP)

Outpatient clinic for patients with a suspicion of Lung Cancer

Tel: 905-521-6190 **Fax:** 905-540-6581

Surname:	Given Name:	Date of Referral (dd/mm/yyyy):	
Street:	City:	Province:	Postal Code:
Contact Number:	Work Phone:	Date of Birth (dd/mm/yyyy):	Gender: ❑ M ❑ F ❑ Other_____
OHIP Number:	VC:	Translator Required: ❑ Yes ❑ No	Language (specify):
Name of Alternate Contact:	Phone Number:	Relationship:	

Additional / Relevant Information:

↓ REPORTS MUST BE ATTACHED ↓

Suspicion of Lung Cancer due to results of:

❑ **CT scan**	Date: (dd/mm/yyyy)	Location:
If CT not completed state:	*Date Ordered:* (dd/mm/yyyy)	*Location:*
❑ **MRI Chest**	Date (dd/mm/yyyy)	Location:

Please attach the following:

- ❑ Past Medical History /CPP
- ❑ List of current medications
- ❑ Report with recent CBC, Creat, INR, PTT (if available)

Notes:

By signing this form, I confirm that this patient is aware of the referral.

Patient must be ready to proceed with appointments and diagnostic tests at the time of referral.

Referring Physician: (Print first name, last name)	Billing #:
Phone Number:	Fax Number:

Referring Physician Signature: ×_____ **Date:** (dd/mm/yyyy) _____

Please ensure referral is complete. Incomplete forms will be returned.

St. Joseph's Healthcare Hamilton

LDAP OFFICE: 905-521-6190