

**PEEL REGIONAL CANCER PROGRAM  
REGIONAL THORACIC SURGICAL ONCOLOGY REFERRAL FORM**

*Select campus where patient will be seen*

- Credit Valley Campus                       Trillium Campus  
 Halton Health Campus                       William Osler Campus

Telephone - 1-866-530-4464   ■   Fax - 1-877-530-4425

Referring Physician: \_\_\_\_\_ Physician Billing No.: \_\_\_\_\_

- Family Physician       Emergency Physician       Respiriologist       Other: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Unit # (if applicable) \_\_\_\_\_ HCN: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Alternate Telephone No.: \_\_\_\_\_

Languages Spoken: \_\_\_\_\_

Next of Kin/Patient Rep.: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Is patient aware of possible diagnosis?     YES       NO

**Appointment with:**     Respirologist     Thoracic Surgeon     Either

**Reason for Referral:**

**Within 10 business days**

- chest x-ray suspicious for lung cancer
- peripheral nodules/mass
- non peripheral nodules/mass
- multiple pulmonary nodules
- pleural effusion
- mediastinal/hilar lymphadenopathy
- interstitial infiltrates
- slowly/non resolving pneumonia
- mediastinal mass
- chest wall mass
- persistent minor hemoptysis
- other \_\_\_\_\_

**Urgent (<24hrs)**

- clinical symptoms - suspicious for lung cancer
- hemoptysis - Frank
- SVC syndrome
- stridor

	Completed		Date
ECG/Blood Tests	Y	N	
PFT/ABG	Y	N	
CT Head	Y	N	
Bone Scan	Y	N	
+/- 2D Echo	Y	N	
PET scan	Y	N	

Ct scan done within past month?     YES\*       NO

**\* If YES, patient must bring films or preferably CD of CT**

