

LUNG DIAGNOSTIC ASSESSMENT PROGRAM (Lung DAP)

(Moderate to high suspicion of malignant disease)

PHYSICIAN REFERRAL FORM

Patient Details		Physician Details	
Name	Health Card	Name	Phone
Date of Birth	Phone	Fax	Address 1
Address 1	Address 2	Address 2	
Presenting Illness/Reason for Referral:			
Pulmonary or pleural nodules/masses suspicious for malignancy Mediastinal and/or hilar adenopathy suspicious for malignancy Non-resolving pleural effusion with suspicion of underlying malignancy Non-resolving lung consolidation/pneumonia despite appropriate antibiotic therapy suspicious for underlying malignancy			
Please fax us the following information:			
Completed referral form CT Chest report (Please order a CT Chest if not already completed. Patients will not be seen in clinic without a completed CT Chest.) Recent blood work, PFT's or other imaging reports List of current medications (including ALL anticoagulants, antiplatelets, NSAIDS and bronchodilators) Past medical history			
Patient Aware of Referral?		Yes	No
Patient Aware of Potential Cancer Diagnosis?		Yes	No
Physician Printed Name:		Date: (yyyy/mm/dd)	
_____		_____	
Physician Signature:			

Fax Number: (613) 546-8225 - Email: dap@kingstonhsc.ca Lung DAP h Navigator kV Telephone: (613) 544-3400 x 2474 *Please see page 2 for entry criteria*			
DAP Office Use Only <input type="checkbox"/> NN Consult <input type="checkbox"/> Access Tool			