



# THORACIC DIAGNOSTIC ASSESSMENT PROGRAM (DAP) REFERRAL FORM

Royal Victoria Regional Health Centre  
201 GEORGIAN DRIVE, BARRIE, ONTARIO L4M 6M2  
Phone: (705) 728-9090 x 43519 Fax: (705) 739-5636

**\*\*\*CT must be ordered for all patients referred to the Thoracic DAP \*\*\***

PATIENT INFORMATION			
Surname	First Name	Gender <input type="checkbox"/> F <input type="checkbox"/> M	D.O.B. (dd/mm/yyyy)
Address	City/Province	Postal Code	Phone Number
RVH V# (if applicable)	OHIP # (with version code)	Patient Email Address	
Name of Preferred Pharmacy		Name of Family Physician	
<b>Required Questions:</b>	If we call the patient, can we leave a voice message? Is the patient asymptomatic? Is the patient a smoker? <b>Medication Questions:</b> Is the patient on anticoagulants? Is the patient on antiplatelets? Is the patient on ASA/NSAIDS? Other Medications – <b>Please attach to referral</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, specify: <input type="checkbox"/> No <input type="checkbox"/> Yes, specify: <input type="checkbox"/> No <input type="checkbox"/> Yes, specify:	
<b>Reason for Referral:</b>	<input type="checkbox"/> Possible Lung Cancer (abnormal CXR, lung nodule or worrisome symptoms such as hemoptysis) <input type="checkbox"/> Possible Esophageal Cancer (based on imaging, endoscope or worrisome symptoms such as dysphagia) <input type="checkbox"/> Mediastinal Mass or Tumour (based on abnormal imaging) <input type="checkbox"/> Pleural Disease (such as pleural effusion, pneumothorax) <input type="checkbox"/> Metastatic Cancer to the Chest <input type="checkbox"/> Other:		
<b>Investigations to Date:</b>	<input type="checkbox"/> CXR <input type="checkbox"/> CT Chest <input type="checkbox"/> PFTs <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Procedure Notes <input type="checkbox"/> Consultation Notes		
	<input type="checkbox"/> Other Tests:		
	<input type="checkbox"/> Abnormal Imaging: Date: _____ Location: _____ Type: _____		
Significant Medical History/Concerning Symptoms: <b>(Please attached additional medical history)</b>			
REFERRING PHYSICIAN INFORMATION			
Referring Physician Name		Billing #	Date
Referring Physician Address		Phone #	Fax #
Referring Physician Signature			

**Please FAX referral to 705-739-5636**