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 ☐ F ☐ 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	

Required Questions:	If we call the patient, can we leave a voice message?	☐ No ☐ Yes
	Is the patient asymptomatic?	☐ No ☐ Yes
	Is the patient a smoker?	☐ No ☐ Yes
	Medication Questions:	
	Is the patient on anticoagulants?	☐ No ☐ Yes, specify:
	Is the patient on antiplatelets?	☐ No ☐ Yes, specify:
	Is the patient on ASA/NSAIDS?	☐ No ☐ Yes, specify:
	Other Medications – **Please attach to referral**	

Reason for Referral:

- ☐ Possible Lung Cancer (abnormal CXR, lung nodule or worrisome symptoms such as hemoptysis)
- ☐ Possible Esophageal Cancer (based on imaging, endoscope or worrisome symptoms such as dysphagia)
- ☐ Mediastinal Mass or Tumour (based on abnormal imaging)
- ☐ Pleural Disease (such as pleural effusion, pneumothorax)
- ☐ Metastatic Cancer to the Chest
- ☐ Other:

Investigations to Date:

☐ CXR	☐ CT Chest	☐ PFTs	☐ Pathology Reports	☐ Procedure Notes	☐ Consultation Notes

☐ Other Tests:

☐ Abnormal Imaging: Date: _____ Location: _____ Type: _____

Significant Medical History/Concerning Symptoms: **(Please attached additional medical history)**

REFERRING PHYSICIAN INFORMATION		
Referring Physician Name	Billing #	Date
Referring Physician Address	Phone #	Fax #
Referring Physician Signature		

Please FAX referral to 705-739-5636