



York Thoracic Surgery

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THORACIC REFERRAL FORM Diagnostic Assessment Program



SOUTHLAKE
REGIONAL HEALTH CENTRE

Referral Date (YYYY/MM/DD) _____/_____/_____

PATIENT INFORMATION

Surname _____ First Name _____ DOB _____ Gender _____

OHIP/HIN # _____ Preferred Phone # _____

Street Address _____ City _____ Postal Code _____

Patient Location Home Hospital _____

REASON FOR REFERRAL

- | | |
|---|---|
| <input type="checkbox"/> Diagnostic Imaging Suspicious of Lung Cancer | <input type="checkbox"/> Clinical Symptoms Suspicious of Lung |
| <input type="checkbox"/> Peripheral nodule or mass in smoker | <input type="checkbox"/> Massive hemoptysis |
| <input type="checkbox"/> Non-peripheral mass or nodule in smoker | <input type="checkbox"/> Non-Massive hemoptysis |
| <input type="checkbox"/> Nodule or mass in non-smoker | <input type="checkbox"/> Superior Vena Cava Syndrome (SVC) |
| <input type="checkbox"/> Multiple pulmonary nodules | <input type="checkbox"/> Stridor |
| <input type="checkbox"/> Pleural effusion | |
| <input type="checkbox"/> Mediastinal or hilar adenopathy | |
| <input type="checkbox"/> Slowly or non-resolving pneumonia | |
| <input type="checkbox"/> Other: _____ | |

***PLEASE ATTACH CREATININE RESULTS NO OLDER
THAN 90 DAYS***

URGENCY: Emergent (<72 hrs – please call YTSA) Urgent (<2weeks)

PLEASE INCLUDE ALL INFORMATION PERTINENT TO REFFERAL

(consults, imaging reports, Bone Scan, PFT, Echocardiogram, recent blood work etc.)

Date of suspicious CXR/CT scan _____/_____/_____ in clinic / hospital _____

Other tests ordered/booked _____

Relevant Medical History _____

REFERRING PHYSICIAN _____

Billing # _____ Phone _____ Fax _____

FAMILY PHYSICIAN _____

Billing # _____ Phone _____ Fax _____

Preferred Location of Consultation

Patient to be seen at: Newmarket Barrie OSMH (Orillia) HHCC (Orangeville) SMH (Alliston) SRCC