Waterloo Wellington
Regional Cancer Program
Ontario Health (Cancer Care Ontario)

Lung Diagnostic Assessment Program Referral Form

Please note:

- For an inpatient or urgent consult, please contact the respirologist on call at WRHN @ Midtown (formerly Grand River Hospital): 519-749-4300
- A CT chest is **required** for the specialist consult
- Biopsies are **not** done on the first visit

Referral Date:
YYYY MM DD

Patient Information		**Referring Physician Information**
Health Card Number:	Preferred Language: ☐ English ☐ Other:	Name:
VC:	Restricted Mobility: ☐ Yes ☐ No	Phone:
Last Name:	First Name:	Fax:
DOB: YYYY MM DD	Sex at birth: ☐ Male ☐ Female Gender Identity:	Street Address:
Street Address:	City/Town:	City/Town:
Province:	Postal Code:	Email:
Phone (home):	Phone (cell):	Billing Number:
Email:	Patient consents to leave message: ☐ Yes ☐ No	Signature:
	Patient consents to receive information by email: ☐ Yes ☐ No	

Medical History

A CT chest is **required** for the specialist consult. Abnormal CT chest (include CT report): Date of suspicious CT
YYYY MM DD

Abnormal chest x-ray (include x-ray report: Date of suspicious x-ray
YYYY MM DD

Indicate all that apply:
☐ Blood work included with creatinine
☐ Allergic to contrast ☐ Diabetic ☐ Taking Metformin ☐ On blood thinner

Clinical Information

Brief history, updated medication list, PFTs and blood work, if available:

Previous Tests and Consultations:

Test	Date	Location

Has the patient had a previous visit with a respirologist? ☐ Yes ☐ No Name:

Is this referral in follow-up to a Lung-RADS® score of 4B or 4X as part of the Ontario Lung Screening Program?
☐ Yes ☐ No

Please send completed referral and all related reports to:

Fax: (519) 749-4384
Phone: (519) 749-4300 ext. 5458