Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

South East Regional Cancer Program
Ontario Health (Cancer Care Ontario)

LUNG DIAGNOSTIC ASSESSMENT PROGRAM (Lung DAP)

(Moderate to high suspicion of malignant disease)

PHYSICIAN REFERRAL FORM	
Patient Details	**Physician Details**
Name Click here to enter text. Health Card Click here to enter text. Date of Birth Click here to enter text. Phone Click here to enter text. Address 1 Click here to enter text. Indigenous Ancestry ☐ **yes** ☐ **no** ☐ **unknown**	Name Click here to enter text. Phone Click here to enter text. Fax Click here to enter text. Address 1 Click here to enter text. Address 2 Click here to enter text.
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 <u>confirm</u> the following information: CT Chest (date and location) _____ (Please order CT Chest it not completed. Patients will **<u>not</u>** be seen without a completed CT) **Please include the following information with your referral:** • Past Medical History • Current Medications • Prior PFTs (if available) **Pending or Requested imaging studies:** (Location and date if known)_____	
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 Nurse Navigator Telephone: (613 549-6666 ext. 7184**	
DAP Office Use Only ☐ NN Consult ☐ Access Tool	