Lakeridge Health | NHH Northumberland Hills Hospital | PRHC Peterborough Regional Health Centre | Central East Regional Cancer Program, Ontario Health (Cancer Care Ontario)

Central East Thoracic Diagnostic Assessment Program

Fax: 1−877−291−5956 Tel: 1−866−338−1778 Ex. 32169

Date of Referral: _____ (dd/mm/yyyy) ❒ Patient has been informed of this referral

Referring Physician
Name: _____
Phone: _____ Fax: _____
Physician Signature: _____
Physician Billing Number: _____

Primary Care Provider (if differs from referring)
Name: _____
Phone: _____
Fax: _____

Patient Information (name as it appears on Health Card)
HCN: _____ VC: _____ Date of Birth: _____ (dd/mm/yyyy)
Surname: _____ Given Name: _____ Initial: _____
Address: _____
City/Town: _____
Postal Code: _____ Home Phone: _____ Work: _____

Preferred Location: ❒ Oshawa ❒ Peterborough ❒ Cobourg ❒ 1st available

Reason for Referral:
❒ Benign
❒ Confirmed/Suspicious for malignancy
❒ Malignant Pleural Effusion (MPE) for effusion due to malignancy *****Oshawa location only*****

Information required for Consult: Include reports/ notes with referral
- Past medical and surgical history
- Current medications
- CT chest − within 3 months of referral (for any confirmed / suspicious lung malignancy)
- CT chest/abd/pelvis within 3 months of referral (for confirmed / suspicious esophageal malignancy)
- CXR (for any MPE referral)
- Symptoms related to reason for referral _____
- Endoscopy and most recent clinic notes (if completed outside Central East)

Tests Completed / Pending	Date: Complete or Scheduled	Test Location
CXR		
CT		
MRI		
Nuclear Medicine		
PFT		
Pathology		
PET Scan		
Other:		

**** If information is from a location outside of the Central East (i.e. Greater Niagara Medical Imaging (GNMI)**