Lakeridge Health | SHN | PRHC Peterborough Regional Health Centre | Central East Regional Cancer Program, Ontario Health (Cancer Care Ontario)

# Central East Thoracic Clinic & 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

The Thoracic Clinic and DAP will provide patients in the Central East with timely access to an interdisciplinary team. Members of the team include: thoracic surgeon, radiologist, pathologist, nurse navigator (RN) and other health disciplines. The Nurse Navigator will facilitate the plan of care.

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

**Family Physician (if differs from referring MD):**
Name:
_____
Phone: _____
Fax: _____

**Patient Information (name as it appears on Health Card)**
HCN# _____ VC _____
Surname: _____ Given Name: _____ Initial: _____
Address: _____ Town: _____
Postal Code: _____ Home Phone: _____ Work: _____
Contact: _____ Date of Birth: _____

**Specify Preferred Assessment Centre:** ❒ Oshawa ❒ Peterborough ❒ Scarborough ❒ 1st available

**Reason for Referral:** ❒ Known malignancy ❒ Suspicious for malignancy ❒ Benign
❒ Pleural Effusion suspicious for malignancy **(Malignant Pleural Effusion Clinic Oshawa location only)**

**Clinical Information:**

| Tests Completed/Pending | Date | Location |
|---|---|---|
| X−ray | | |
| CT | | |
| MRI | | |
| Nuclear Medicine | | |
| Pathology | | |
| Other: _____ | | |

**Thoracic Clinic Use Only**

**Priority 1 2 3 4**

**Appointment Date and Time:** _____ **NN Signature** _____