DIAGNOSTIC ASSESSMENT PROGRAM

❏ LUNG DAP

All information *MUST* be complete. Incomplete referrals will be returned.

PHYSICIAN REFERRAL FORM

Patient Details		Physician Details	
Patient Name:	**DOB:** ___ / _____ / ___ (dd/mmm/yy)	**Referring Physician:**	**CPSO#**
Address:	**City:**	**Telephone:**	**Fax:**
Postal Code:	**M**___ **F**___	**Family Physician/Nurse Practitioner:**	
Telephone 1: **Telephone 2:**	**Interpreter** ❏ **Language:** ___________	**Patient notified of referral to DAP:** ❏ Yes ❏ No **Patient aware of cancer risk:** ❏ Yes ❏ No **Date patient informed:** ___________ ***Patient MUST be informed of referral reason**	
HCN & VC:			

History of presenting illness / concern: ______________________________

____

____

Smoking History:

Allergies:

LUNG DIAGNOSTIC ASSESSMENT PROGRAM

REASON FOR REFERRAL Note: Patient ***must*** meet one of the following referral criteria:

- ❏ Solitary pulmonary nodules (0.5 - 3.0cm)
- ❏ Abnormal CXR including mass, atelectasis or adenopathy
- ❏ Pneumonia non responsive to antibiotics in 4 weeks
- ❏ Recurrent non massive hemoptysis
- ❏ Non resolving pleural effusions with lung lesions
- ❏ Hoarseness with lung mass or adenopathy
- ❏ Pancoast tumor (pain shoulder area/arms, drooping eyelid, tumor in superior sulcus of lung)
- ❏ Lung mass with obvious metastatic disease (bone pain, jaundice, weight loss >10% of body weight)
- ❏ Lung lesions or pleural effusions in the presence of previous malignancies

DIAGNOSTIC TESTS: ** MUST BE COMPLETED & REPORTS INCLUDED WITH REFERRAL **

DIAGNOSTIC TEST:	Ordered by	Date	Facility
Chest X-ray			
CT Scan - chest, liver & adrenals			
CBC, SMA7, INR, PTT, Alkaline Phosphatase, Bilirubin, AST, ALT, Calcium, Albumin, Creatinine			
DIAGNOSTIC TESTS: PLEASE INCLUDE REPORT IF COMPLETE OR INDICATE IF ORDERED.			
Pulmonary Function Test			

Preferred Respirologist or Surgeon: ______________________________

Preferences honoured provided consultation with PT occurs within 14 days.

The Lung DAP *Nurse Navigator* **Phone: 519-254-5577 ext. 58614**	**Physician signature:**	**Date:**

Fax completed forms to: 519-255-8688

DIAGNOSTIC ASSESSMENT PROGRAM

❏ PROSTATE DAP

All information ***MUST*** be complete. Incomplete referrals will be returned.

PHYSICIAN REFERRAL FORM

Patient Details		Physician Details	
Patient Name:	**DOB:** ___ / _____ / ___ (dd/mmm/yy)	**Referring Physician:**	**CPSO#**
Address:	**City:**	**Telephone:**	**Fax:**
Postal Code:	**M**___ **F**___	**Family Physician/Nurse Practitioner:**	
Telephone 1: **Telephone 2:**	**Interpreter** ❏ **Language:** __________	**Patient notified of referral to DAP:** ❏ Yes ❏ No **Patient aware of cancer risk:** ❏ Yes ❏ No **Date patient informed:** __________ ***Patient MUST be informed of referral reason**	
HCN & VC:			

History of presenting illness / concern: ____

____

____

Smoking History:

Allergies:

PROSTATE DIAGNOSTIC ASSESSMENT PROGRAM

REASON FOR REFERRAL Note: Patient ***must*** be ≤ 75 years and meet one of the following referral criteria:

- ❏ **PSA ≥ 10**
- ❏ **3 consecutive rising PSAs at 2-3 month intervals; first PSA ≥ 4**
- ❏ **High Risk:** First degree relative diagnosed ≤ 60 yrs.
- ❏ **Previous negative biopsy:** PSA continues to rise
- ❏ **Abnormal Digital Rectal Exam:**
  Please note findings: ______________________
  ____

DIAGNOSTIC TESTS: Copies of test results must accompany referral

PSA:

Date: ________	Date: ________	Date: ________
Free Ratio: ________	Free Ratio: ________	Free Ratio: ________
Total Ratio: ________	Total Ratio: ________	Total Ratio: ________

Urinalysis & Culture: Date________ Result ______________________________

OTHER DIAGNOSTIC TESTS: Not required, but may have been completed.

TRUS Biopsy:	Date: ________	Location: ________	Result: ____________
CT/Bone Scan:	Date: ________	Location: ________	Result: ____________

Preferred Urologist: ______________________________________

Preferences honoured provided consultation with PT occurs within 14 days.

The Prostate DAP *Nurse Navigator*
Phone: 519-254-5577 ext. 58613

Physician signature: **Date:**

Fax completed forms to: 519-255-8688