

# LUNG DIAGNOSTIC ASSESSMENT PROGRAM (LDAP)

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

<b>PHYSICIAN REFERRAL FORM</b>	
Patient Details	Physician Details
Patient Name:	Referring Physician Name:
Street Address:	CPSO #:
City:	Telephone #:
Postal Code:	Fax #:
Phone Number—Home:	Patient notified of referral to LDAP: <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone Number—Cell:	Patient aware of cancer risk: <input type="checkbox"/> Yes <input type="checkbox"/> No
DOB: mm / dd / yyyy <input type="checkbox"/> Male <input type="checkbox"/> Female	Date patient informed: mm / dd / yyyy
HCN: _____ VC: _____	<b>Patient <u>MUST</u> be informed of referral reason</b>
Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No Language: _____	
History of presenting illness / concern:	

<b>LUNG DIAGNOSTIC ASSESSMENT PROGRAM</b>		
<b>REASON FOR REFERRAL</b> - Patient <u>must</u> meet one of the following referral criteria:		
<table style="width:100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> Solitary pulmonary nodules (0.5 - 3.0 cm)  <input type="checkbox"/> Hoarseness with lung mass or adenopathy  <input type="checkbox"/> Pneumonia non responsive to antibiotics in 4 weeks  <input type="checkbox"/> Recurrent non massive hemoptysis  <input type="checkbox"/> Non resolving pleural effusions with lung lesions                 </td> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> Abnormal CXR including mass, atelectasis or adenopathy  <input type="checkbox"/> Pancoast tumor (pain shoulder area/arms, drooping eyelid, tumor in superior sulcus of lung)  <input type="checkbox"/> Lung mass with obvious metastatic disease (bone pain, jaundice, weight loss less than 10% of body weight)  <input type="checkbox"/> Lung lesions or pleural effusions in the presence of previous malignancies                 </td> </tr> </table>	<input type="checkbox"/> Solitary pulmonary nodules (0.5 - 3.0 cm) <input type="checkbox"/> Hoarseness with lung mass or adenopathy <input type="checkbox"/> Pneumonia non responsive to antibiotics in 4 weeks <input type="checkbox"/> Recurrent non massive hemoptysis <input type="checkbox"/> Non resolving pleural effusions with lung lesions	<input type="checkbox"/> Abnormal CXR including mass, atelectasis or adenopathy <input type="checkbox"/> Pancoast tumor (pain shoulder area/arms, drooping eyelid, tumor in superior sulcus of lung) <input type="checkbox"/> Lung mass with obvious metastatic disease (bone pain, jaundice, weight loss less than 10% of body weight) <input type="checkbox"/> Lung lesions or pleural effusions in the presence of previous malignancies
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<b>DIAGNOSTIC TESTS</b>			
** DI TESTS THAT MUST BE COMPLETED **			
Diagnostic Test	Ordered By	Date (mm/dd/yyyy/)	Facility
Chest X-ray			
CT Scan (Chest, Liver & Adrenals)			
Other DI TESTS			
Diagnostic Test	Ordered By	Date (mm/dd/yyyy/)	Facility
Pulmonary Function Test			
CBC, SMA7, INR PTT, Alkaline Phosphatase, Bilirubin, AST, ALT, Calcium, Albumin, Creatinine			

If you have any questions, please contact the LDAP at: 519-254-5577 ext. 55527

Physician Signature: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_\_

<b>Fax completed forms to: 519-985-2668</b>
Patients should expect to be notified within 5 business days