St. Joseph's Healthcare Hamilton | Brant Community Healthcare System | Niagara Health System / Système de santé de Niagara

REGIONAL LUNG DIAGNOSTIC ASSESSMENT PROGRAM (Lung DAP)

REGIONAL ESOPHAGEAL DIAGNOSTIC ASSESSMENT PROGRAM (Esophageal DAP)

- ❑ Urgent referral for possible lung cancer
- ❑ Urgent referral for possible esophageal or gastric cancer
- ❑ Undifferentiated Pulmonary Nodule
- ❑ Suspected Malignant Pleural Effusion

Tel: 1-877-801-4822 905-521-6190	**Fax:** 1-877-803-4422 905-540-6581	**Email:** ldap@stjoes.ca edap@stjoes.ca

Surname:	Given Name:		Date of Referral (yyyy/mmdd):	
Street:		City:	Province:	Postal Code:
Home Phone:	Work Phone:		Date of Birth (yyyy/mm/dd):	Gender: ❑ M ❑ F
OHIP Number:		VC:	❑ Translator Needed Language:	
Primary Contact Name:	Primary Phone Number:		Relationship:	

! Please fax consultant notes including ***history of patient, blood work*** and ***current medications***, ***X-ray, CT-Scan, pathology/cytology*** and other ***pertinent reports***.

The Problem: (Reason to suspect lung or esophageal cancer)

- ❑ X-ray suspicious of cancer
- ❑ CT-scan suspicious of cancer
- ❑ Clinical symptoms suspicious of cancer
- ❑ Gastroscopy suspicious of cancer
- ❑ Inability to Swallow
- ❑ Esophageal Stricture
- ❑ Weight Loss
- ❑ Smoker ❑ Non Smoker

Has CT been ordered
- ❑ No
- ❑ Yes – Where: _____
  When: _____

Other, specify: _____

_____

_____

Please send ***suspicious imaging if available with patient***

Patient History:

_____

_____

Investigations to Date:

_____

_____

⬇ This Area Must Be Completed ⬇

Date of Patient's Initial Consult with Referring Physician:

_____
YYYY / MM / DD

Signature of Referring Physician

× _____
SIGNATURE

_____
YYYY / MM / DD

Referring Physician Name (print):	**CPSO Number:**	**Phone:**	**Fax:**