MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Proud member of
East Toronto Health Partners

THORACIC DIAGNOSTIC ASSESSMENT CLINIC REFERRAL FORM (TIME TO TREAT)

TEL: (416) 469-6031 FAX: (416) 469-6458

REF

Patient ID Label

Patient Last Name:	Given Name:	☐ M ☐ F	Date of Birth: (DD / MMM / YYYY)
Address:	Apt#:		Telephone Number – Primary Number: ( )
Town or City:	Province:	Postal Code:	Telephone Number – Work Number: ( )
Contact Person (Caregiver/Parent/Guardian):	Relationship To Patient:		Telephone Number - Contact Person: ( )
Family Physician:	**Ontario Health Card Number:** Version Code		**Email Address For Virtual Consult:**

Height (cm):	Weight (kgs):	Allergies: ☐No ☐Yes ☐Unknown

Required Questions:	PRIVACY: If we call the patient, can we leave a voice message? ☐No ☐Yes WSIB: Is this treatment due to a work related injury? ☐No ☐Yes American Sign Language interpreter required? ☐No ☐Yes Language interpreter required? - specify: ☐No ☐Yes	**Is the patient asymptomatic? ☐No ☐Yes** **Is the patient a smoker? ☐No ☐Yes**

Referred To: **T – Thoracic Surgeon** **R- Respirologist**	☐ First Available Appointment (within 7 days)			Referral Date:
	☐ Dr. Negar Ahmadi (T)	☐ Dr. Najib Safieddine (T)	☐ Dr. Carmine Simone (T)	
	☐ Dr. Sayf Gazala (T)	☐ Dr. I Fraser (R)	☐ Dr. M. Kargel (R)	
	☐ Dr. C. Walsh (R)	☐ Dr. D. Bain (R)	☐ Dr. A. Vagaon (R)	

Reason For Referral:

- ☐ Possible Lung Cancer (abnormal CXR, lung nodule or worrisome symptoms such as hemoptysis)
- ☐ Possible Esophageal Cancer (based on imaging, endoscope or worrisome symptoms such as dysphagia)
- ☐ Mediastinal Mass or Tumour (based on abnormal imaging)
- ☐ Pleural Disease (such as pleural effusion, pneumothorax)
- ☐ Benign Esophageal Disease (such as hiatus hernia, GERD or achalasia based on abnormal imaging or symptoms)
- ☐ Metastatic Cancer to the Chest
- ☐ Other:

Investigations To Date: ☐ CT Chest ☐ PFTs: ☐ CXR ☐ Pathology Reports ☐ Procedures Notes ☐ Consultation Notes ☐ MRI Chest ☐ Other Tests:

Current Problems:

Past Medical History:

Medications:

Referring Physician:	Physician Name:	
	Telephone Number: ( )	Fax Number: ( )
	Physician's Signature:	Billing#:

Appointment Information:	

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Ontario eServices Program

We now accept Ocean eReferrals for various clinics. The best way to find Specialist and refer your patients. For more information and to sign-up for your Ocean user account, contact Ontario eHealth at **eReferral@ehealthce.ca**