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) 469-6580 ext 3475 **FAX: (416) 469-**7753

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)

☐ Dr. S. Gazala (T)	☐ Dr. N. Safieddine (T)	☐ Dr. C. Simone (T)
☐ Dr. D. Bain (R)	☐ Dr. L. Kim (R)	☐ Dr. N. Ahmadi (T)
☐ Dr. C. Walsh (R)	☐ Dr. A. Vagaon (R)	☐ Dr. M. Kargel (R)

Referral Date:

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:

Ocean by CognisantMD
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**