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

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. Sayf Gazala (T)	☐ Dr. Najib Safieddine (T)	☐ Dr. Carmine Simone (T)
☐ Dr. D. Bain (R)	☐ Dr. I Fraser (R)	☐ Dr. M. Kargel (R)
☐ Dr. C. Walsh (R)	☐ Dr. A. Vagaon (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:

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**