Trillium Health Partners

mississauga halton /central west regional cancer program

in partnership with cancer care ontario

DIAGNOSTIC ASSESSMENT PROGRAM

Credit Valley Hospital, 2200 Eglinton Avenue West, Mississauga, ON, L5M 2N1, 1-866-530-4464

Physician Referral Form Date: ______________________

Patient Name: ______________________________

DOB: ________________ Sex: ______

Health Card #: ______________________________

Address: ______________________________

City: __________________ PC: ______________

Phone #: ___________________

Physician Details – By signing this form, I confirm that this patient is aware of this referral.

Referring Physician Name: _________________________ Billing #: _________________________

Referring Physician Signature: _________________________ Phone #: _________________________

Family Physician Name: _________________________ Fax #: _________________________

Has the patient been seen previously in the Diagnostic Assessment Program? ☐ Yes ☐ No

Is the patient Ambulatory? ☐ Yes ☐ No Is the patient currently in Hospital? ☐ Yes ☐ No

BREAST DIAGNOSTIC ASSESSMENT PROGRAM

ALL breast imaging reports performed in the last 2 years must be attached, including most recent mammogram and/or ultrasound. Please ensure patient brings all outside breast images to the DAU at least 2 days prior to their appointment.

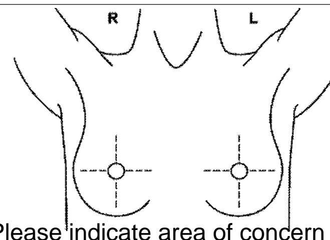
All incomplete referrals will be sent back to the referring physician and may lead to delays.

Reason for Referral: ☐ Palpable Abnormality ☐ Abnormal Breast Imaging (mammogram, ultrasound) ☐ Bloody Nipple Discharge ☐ Other (please specify):

Mammogram pending/done: ☐ Yes (where/when: ______________________) ☐ No

Ultrasound pending/done: ☐ Yes (where/when: ______________________) ☐ No

Previous Breast Cancer? ☐ Yes ☐ No



Please indicate area of concern

HEPATO-PANCREATIC-BILIARY DIAGNOSTIC ASSESSMENT PROGRAM

If a CT scan and/or MRI has been completed in the last 2 months, please fax report & have patient bring outside images to their appointment.

Reason for Referral: ☐ Pancreatic mass ☐ Liver mass ☐ Gallbladder / Biliary mass ☐ Other (please specify): ____________

Please indicate if any of the following tests have been completed & attach report:

☐ CBC/GBCL/LFT/INR ☐ AFP ☐ CEA ☐ CA19-9 ☐ Chronic Hepatitis Serology ☐ CXR / CT chest ☐ PET scan

THORACIC DIAGNOSTIC ASSESSMENT PROGRAM

Please attach CT scan report & consult notes along with any other pertinent information (ie. Other imaging, bloodwork, etc.). Please ensure patient brings any outside CT scan images to their appointment.

Reason for Referral: ☐ Suspicion for Lung Cancer ☐ Suspicion for Gastro-Esophageal Cancer ☐ Other (eg. Mediastinal Disease): ____________

Select Campus where patient will be seen: ☐ CVH Site ☐ Trillium Site ☐ Brampton Civic ☐ Halton Healthcare

If CT is not arranged, please indicate all that apply (please attach serum creatinine done within 28d):

☐ Renal Insufficiency ☐ Allergic to Contrast ☐ Diabetic on Metformin ☐ On Anticoagulant – Medication:

Notes:

1019 D HR (March/2015)

FAX COMPLETED FORMS & RELEVANT REPORTS TO: 1-877-530-4425

Patient will be contacted with appointment and a confirmatory fax sent to you / DIAGNOSTIC ASSESSMENT PROGRAM