

**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 relevant consultant notes including **history of patient (cumulative patient profile), current 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 | ☐ Inability to Swallow | Has CT been ordered
☐ No
☐ Yes – Where: _____
When: _____ |
| ☐ CT-scan suspicious of cancer | ☐ Esophageal Stricture | |
| ☐ Clinical symptoms suspicious of cancer | ☐ Weight Loss | |
| ☐ Gastroscopy suspicious of cancer | | |

Other, specify: _____

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

Relevant History of Patient:

Investigations to Date:

↓ **This Area Must Be Completed** ↓

Signature of Referring Physician

x _____
 SIGNATURE YYYY / MM / DD

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