WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

LUNG CANCER ASSESSMENT PROGRAM (LCAP)

All information ***MUST*** be complete. Incomplete referrals **will be** returned.

PHYSICIAN REFERRAL FORM

Patient Details	Physician Details
Patient Name:	Referring Physician Name:
Street Address:	Billing #:
City:	Telephone #:
Postal Code:	Fax #:
Phone Number—Home:	Patient notified of referral: ☐ Yes ☐ No
Phone Number—Cell:	Patient aware of cancer risk: ☐ Yes ☐ No
Email:	Date patient informed: mm / dd / yyyy
DOB: mm / dd / yyyy ☐ Male ☐ Female	Does Patient see a respirologist? ☐ Yes, who? _____ ☐ No
HCN: VC:	Interpreter: ☐ Yes, language:_____ ☐ No
History of presenting illness / concern:	

Reason for Referral - Patient must meet one of the following criteria

- ☐ Solitary pulmonary nodules (0.5 - 3.0 cm)
- ☐ Hoarseness with lung mass or adenopathy
- ☐ Pneumonia non responsive to antibiotics in 4 wks
- ☐ Recurrent non massive hemoptysis
- ☐ Non resolving pleural effusions with lung lesions
- ☐ Abnormal CXR including mass, atelectasis or adenopathy
- ☐ Pancoast tumor (pain shoulder area/arms, drooping eyelid, tumor in superior sulcus of lung)
- ☐ Lung mass with obvious metastatic disease (bone pain, jaundice, weight loss less than10% of body weight)
- ☐ Lung lesions or pleural effusions in presence of previous malignancies

⚠ **Patient must be aware of referral reason**

DIAGNOSTIC TESTS

⚠ **DI TESTS MUST BE COMPLETED**

Diagnostic Test	Ordered By	Date (mm/dd/yyyy/)	Facility
Chest X-ray			
CT Scan (Chest, Liver & Adrenals)			

Other DI TESTS

Diagnostic Test	Ordered By	Date (mm/dd/yyyy/)	Facility
Pulmonary Function Test			
CBC, SMA7, INR PTT, Alkaline Phosphatase, Bilirubin, AST, ALT, Calcium, Albumin, Creatinine			

If you have any questions, please contact the LCAP at: 519-254-5577 ext. 55527 after 2 pm on weekdays.

Physician Signature: _____ **Date** (mm/dd/yyyy)**:** _____

Fax completed forms to: 519-985-2668

Patients will be contacted within 2 weeks to book an appointment. Please ensure all contact information is correct.