UHN Toronto General Toronto Western Princess Margaret Toronto Rehab Michener Institute

# RACE Program Referral Form (Rapid Assessment of Complex Pleural Effusions Program)

**Fax to: 416-340-3001**

Addressograph

Date: ____________________ To: ____________________

Referring MD: ____________________

Reason for referral:

____________________

____________________

____________________

____________________

Previous thoracentesis date (s) : ____________________

Previous pleurodesis:

1. Yes ❑ Left ❑ Right ❑
2. No ❑

Previous indwelling pleural catheter:

1. Yes ❑ Left ❑ Right ❑
2. No ❑

Symptomatic relief with thoracentesis: Yes ❑ No ❑

Primary Malignancy: ____________________

Current treatment of the primary malignancy:

1. Active chemotherapy with curative intent ❑
2. Palliative Chemo ❑ Radiation ❑
3. Palliative pain control ❑

Anticoagulant use: Yes ❑ No ❑

Name: ____________________ Date of the last dose: ____________________

**IN OFFICE USE ONLY**

**Date Referral Received:** ____________________ **Date of Patient Contact:** ____________________