Lung Metastasis Clinic
Assessment & Management Program

ASSESSMENT & MANAGEMENT OF LUNG METASTASIS OF LUNG OR OTHER PRIMARY CANCERS

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PATIENT INFORMATION				
Last Name:	**First Name:**		**Date of Birth (dd/mm/yyyy):**	**Gender:** M F
Health Card #:	**Version:**	**Patient Location Details (Home/Inpatient):**	**Previous UHN Patient: Yes No MRN, if Known:**	
Street Address:				
City:		**Province:**	**Postal Code:**	
Phone (Home):	**Phone (Cell):**		**Phone (Work):**	
Alternate Contact Name:	**Relationship:**		**Phone (Home/Cell):**	
Referring Physician Name:	**Referring Physician Billing Number:**	**Referring Physician Phone:**	**Referring Physician Fax:**	
Referring Physician Email:	**Family Physician Name:**	**Family Physician Phone:**	**Family Physician Fax:**	

Referral to:

☐ **Lung Metastasis Program (Earliest Available)**

☐ Dr T Waddell ☐ Dr M Cypel

Please FAX consultant notes including HISTORY OF PATIENT, BLOOD WORK and CURRENT MEDICATIONS, X-RAY, CT SCAN, PATHOLOGY/CYTOLOGY & other PERTINENT REPORTS.

Suspected Lung Metastasis:

- ○ Chest X-ray Suspicious of Lung Metastasis
- ○ Chest CT-scan Suspicious of Lung Metastasis
- ○ Clinical Symptoms Suspicious of Lung Metastasis
- ○ FNA positive for Lung Metastasis

Reason for Referral:_____

PLEASE NOTE: IF PATIENT'S IMAGING IS NOT FROM MOUNT SINAI HOSP, UHN or WOMEN'S COLLEGE HOSP YOU MUST SEND A CD WITH ALL THE PATIENT'S THORACIC IMAGING SINCE THEIR PRIMARY CANCER WAS DIAGNOSED IN ORDER FOR AN APPOINTMENT TO BE SCHEDULED.

Date of Patient's initial consult with referring physician: _____
(mm/dd/yyyy)

Signature of Referring Physician (Mandatory) _____ **Date:** ____/_____/_____