Northeast Cancer Centre
Health Sciences North
a Cancer Care Ontario partner

Centre de cancérologie du Nord-Est
Horizon Santé-Nord
un partenaire d'Action Cancer Ontario

SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

**IMPORTANT: Do not refer patients to the NE LDAP for emergency management. NE LDAP patients are seen in the NE LDAP physician's office as outpatients. If an inpatient requires consultation prior to hospital discharge please contact the specialist directly as per your usual inpatient referral processes.**

# NE LDAP–OUTPATIENT REFERRAL FORM (ALGOMA CATCHMENT AREA ONLY)

**North East Lung Diagnostic Assessment Program (NE LDAP)**
**Fascimile: 705-523-7287 Phone: 705-523-7100 ext. 2553**

An incomplete referral form may lead to delays in appointment booking
Please complete all fields and FAX to 705-523-7287

**PATIENT INFORMATION**:

Surname: _____ Given name: _____ DOB: _____

Address: (Apartment/Street) _____ City: _____

Province: _____ Postal code: _____

Telephone: Home: _____ Work: _____ Gender: ❒ Male ❒ Female

Health card number and version code: _____

Date of initial presentation of symptoms: _____ Date of referral: _____

Primary care provider: _____ Patient aware of referral: ❒Yes ❒ No

**REASON FOR REFERRAL:** ❒ Chest CT Scan Suspicious of Lung Cancer (required for referral)

Sault Area Hospital Participating Specialist:

❒ Dr. J. Reich (Surgeon) will provide the first consultation and transfer care to a thoracic surgeon if needed.

In the event that patient care is transferred to a thoracic surgeon, please indicate your preference below:
Thoracic surgeon of choice: _____

* In accordance with the NE LDAP guiding principles, diagnostic services will be provided as close to patients' home as possible.

NOTE: Please FAX the following:

❒ Pertinent presenting symptoms and past medical history
❒ Blood work results within last 3 months
❒ Pertinent imaging reports ( ie chest x-ray, CT chest scan)
❒ Pathology/cytology results (if available)
❒ List of medications

Patients must arrive on time and bring with them their Health Card and list of current medications.

**PHYSICIAN INFORMATION**:

Referring physician: _____

Telephone: _____

Fax: _____

Physician number: _____

Please use practice stamp where available

_____ _____
Referring physician signature (mandatory) Date