REGIONAL LUNG DIAGNOSTIC ASSESSMENT PROGRAM REFERRAL FORM REVISION

Item:	**SBAR – Lung Diagnostic Assess Program (LDAP) Regional Referral Form Revision**
Date:	November 28, 2017
Presented by:	Brant Community Healthcare System, Niagara Health, St. Joseph's Healthcare Hamilton
S Situation:	The goal of LDAP is to ensure timely and equal access to care, early detection and treatment of lung cancer, and coordinated care as close to home as possible.
B Background:	The Regional Lung Diagnostic Assessment Program is an outpatient clinic for patients with a suspicion of Lung Cancer. To ensure timely admission and triaging of your patient into the LDAP program, the referral form has been updated to help guide the referring care provider to effectively complete all requirements. The referring care provider must complete all portions of the referral form.
A Assessment & **R** Recommendation:	**All completed referrals are to be sent to the Regional Lung Diagnostic Assessment Program fax line:** **1-877-803-4422 / 905-540-6581** When the completed referral is received, it is triaged to the healthcare center that is closest to the patient's home. Once the referral is received, the outpatient LDAP will connect with the patient to start to coordinate care. It is essential that the patient is aware of the referral that is being submitted on their behalf and that the patients are ready to proceed with appointments and diagnostic tests at the time of referral. All reports that have lead up to the suspicion of lung cancer must accompany the completed referral form. It is highly recommended that where possible, a recent CT of the chest be included with the referral to expedite your patient's appointment. <u>The results/report of the CT is required prior to the initial LDAP physician consultation</u>. If there is no current CT, the patient will be sent for one prior to the initial LDAP visit, by the program. The time it takes to get the initial CT is included in the patients wait time from admission to the program to diagnosis. **Incomplete referrals will be returned to referring care provider.**

Brant Community Healthcare System
LDAP OFFICE
519-751-5544 ext. 5585

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LDAP OFFICE
905-378-4647 ext. 49139

St. Joseph's Healthcare Hamilton
LDAP OFFICE
905-521-6190

REGIONAL LUNG DIAGNOSTIC ASSESSMENT PROGRAM (Lung DAP)

Outpatient clinic for patients with a suspicion of Lung Cancer

Tel: 1-877-801-4822 / 905-521-6190 **Fax:** 1-877-803-4422 / 905-540-6581

Surname:	Given Name:	Date of Referral (DD/MM/YYYY):	
Street:	City:	Province:	Postal Code:
Contact Number:	Work Phone:	Date of Birth (DD/MM/YYYY):	Gender: ❑ M ❑ F ❑ Other___
OHIP Number:	VC:	Translator Required: ❑ Yes ❑ No Language (please specify): _____	
Name of Primary Contact:	Phone Number:	Relationship:	

Additional / Relevant Information:

_____

_____

_____

_____

REPORTS MUST BE ATTACHED

Suspicion of Lung Cancer due to results of:

❑ X-ray	Date:	Location:
❑ CT scan	Date:	Location:
If CT not completed state:	Date Ordered:	Location:
❑ MRI Chest	Date:	Location:

Please attach the following

❑ Past Medical History /CPP ❑ List of current medications ❑ Report with recent CBC, Creat, INR, PTT (if available)

_____

_____

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF REFERRAL.

Patient must be ready to proceed with appointments and diagnostic tests at the time of referral.

Referring Physician (print first, last):	Billing #:
Referring Physician Signature:	Date (DD/MM/YYYY):
Phone Number:	Fax Number:

Please ensure referral is complete. Incomplete forms will be returned.

Brant Community Healthcare System

ONCOLOGY CLINIC
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