Alberta Health Services

Affix patient label within this box

Thoracic Oncology Referral
(Alberta Thoracic Oncology Program/Chest Medicine Clinic - Edmonton, North & Central)

Fax this form and related records to 780.735.3971. Phone 780.735.3970 or 780.735.3972

Referring Physician Information		
Name	Phone	Fax

Patient Information			
Last Name	First Name	PHN	DOB *(yyyy-Mon-dd)*
Address	City		Postal Code
Home Phone	Business Phone	Mobile Phone	
Family Physician *(print name)*			

Reason for Referral *(check all that apply)*

- ☐ Pleural Effusion
- ☐ Lung Lesion/Mass
- ☐ Esophageal Cancer
- ☐ Mediastinal Lymphadenopathy
- ☐ Mediastinal Lesion/Mass
- ☐ Metastatic Lesion
- ☐ Esophageal Benign
- ☐ Hyperhydrosis
- ☐ Pectus Excavatum
- ☐ Other _____

Brief Clinical/Medical history with listed symptoms

Triage Requirements	**Please include the following information *If Available***
☐ Current CT scan of the chest is required for all lung, mediastinal or suspected metastatic lesions ***Please Note: Send CT Chest images by disc if not available on NETCARE to:*** ***RM 4504 - Children's Centre*** ***Royal Alexandra Hospital*** ***10240 Kingsway Avenue Edmonton, AB, T5V 3Z9*** ☐ Esophageal cancer requires a biopsy ***Result*** ☐ Medication List ***(Including oxygen)***	☐ Allergy List ☐ Lab Results/Microbiology/Pathology ☐ consultant/discharge letters ☐ Diagnostic Imaging (including PET/CT if available) ☐ Pulmonary Function Studies