Halton Healthcare

Oakville Trafalgar Memorial Hospital

Patient Demographics

Outpatient Ambulatory Clinics
MALIGNANT PLEURAL EFFUSION (MPE) CLINIC

Outpatient clinic for suspected or confirmed malignant pleural effusions

For suspected or confirmed lung cancer/nodules, please use the LDAP Clinic Referral form

PATIENT REFERRAL

Please FAX completed form to: (905) 338-4685

Patient Information (Please fill or affix sticker)

Surname:	Given Name:	Date of Referral (dd/mm/yyyy):	
Address:	Apt/Unit:	City/Town:	Province:
Postal Code:	Home Phone:	Business Phone:	Date of birth (dd/mm/yyyy):
OHIP Number (including VC):	Expiry Date:	Translator Required: □ Y □ N Language: _____	Gender: □ M □ F □ Other _____
Primary Contact Name / Number:		Relationship:	
Relevant / Additional Information: _____ _____			

REPORTS MUST BE ATTACHED:

Suspicion of a malignant pleural effusion due to the results of:

- □ Primary site of known malignancy — Date of diagnosis: (dd/mm/yyyy) _____
- □ X-ray — Date: (dd/mm/yyyy) _____ Hospital: _____
- □ CT scan — Date: (dd/mm/yyyy) _____ Hospital: _____
- □ Fluid cytology (if drained) — Date: (dd/mm/yyyy) _____ Hospital: _____

If there is positive cytology from a previous pleural fluid sample, please send a copy of the results.

Please attach copies of the following:

- □ Past Medical History
- □ Current Medications
- □ Recent Bloodwork (CBC, Cr, INR, PTT)

Anticoagulation: □ Yes _____ □ No
(Please specify)

⚠ By signing this form, I confirm that the patient is aware of this referral.
Patient must be willing to proceed with the appointments and diagnostic tests/procedures required.

Referring Physician: (Please print)	Billing #:
Phone Number:	Fax Number:
Physician Signature: x_____	**Date:** (dd/mm/yyyy)

INTERNAL USE ONLY:

Date received: _____ Date Patient contacted: _____ Staff Initials: ____

Please ensure this form is complete. Incomplete forms will be returned.

LDAP Telephone: (905) 845-2571, Ext. 4407 **DAP Fax: (905) 338-4685**