William Osler Health System

Division of Thoracic Surgery

REFERRAL FORM

Patient's Name _____ D.O.B. _____

Health Card # _____ Phone # _____

Reason for Referral

- ☐ Lung mass/nodule
- ☐ Gastro-esophageal reflux/Hiatal Hernia
- ☐ Achalasia
- ☐ Other
- ☐ Esophageal Cancer
- ☐ Sympathectomy for Hyperhidrosis
- ☐ Mediastinal Tumour

Relevant Clinical History:

CT Scan of Chest: ☐ Yes ☐ No

Date of CT Scan _____ Hospital _____

Referring Physician _____

Date _____

Appointment

Date _____

Time _____