ASSESSMENT OF MALIGNANT PLEURAL EFFUSION (AMPE) CLINIC REFERRAL FORM

PATIENT INFORMATION LABEL HERE

PLEASE PRINT CLEARLY

Patient Name: _____ Gender: ☐ F ☐ M ☐ Other DOB: _____PHN/MRN:_____

Patient Address:_____ Tel/Home: _____ Tel/Work: _____

Primary Care Provider: _____ Referring MD/NP:_____

Referring MD/NP WORK Email: _____ Tel#:_____ Fax: _____ Bill#:_____

PLEASE REFER THIS PATIENT TO (check ✓one of the following):

☐ Dr. Sen Han Phang ☐ Dr. Iain Magee ☐ First Available ☐ Other _____

PROCEDURE REQUESTED (check ✓ all required exams needed):

☐ Intrapleural Catheter Insertion ☐ Intrapleural Catheter Assessment

URGENCY (*all urgent consults MUST be discussed directly with Drs. Phang or Magee)

☐ Routine (within 4 weeks) ☐ Semi Urgent (within 2 weeks) ☐ Urgent (within 72 hrs)

REASON FOR REFERRAL/ PATIENT HISTORY

_____
_____
_____
_____

Patient history must include: consults, lab and diagnostic results. Failure to complete properly will result in referral being returned.

Cancer Diagnosis: ☐ Lung ☐ Breast ☐ Lymphoma/Heme ☐ GU ☐ GI ☐ Other: _____

Date Diagnosed: _____ 1st Thoracentesis Date:_____ Last Thoracentesis Date: _____

Number of Thoracenteses: _____ INR/PTT: _____*Complete within 1 MTH if on antiplatelets anticoagulation

Allergies (select all that apply): ☐ Tape ☐ Cleaning ☐ Solutions ☐ Lidocaine ☐ Other: _____

Precautions (select all that apply): ☐ Contact ☐ Droplet ☐ Airborne ☐ Other: _____

PLEASE FAX COMPLETED FORM TO: 250-370-8762