BC CANCER LUNG SCREENING
Provincial Health Services Authority

Lung Screening Program: **LDCT Scan Referral Form**

Patients who have a primary care provider can self-refer to the program if they meet the inclusion criteria (outlined in STEP 2). Please have them call the Lung Screening Program at 1-877-717-5864, a referral form is not needed. Otherwise, please complete this form for any patients who you consider may experience barriers to self-referral (e.g. language barrier, screening hesitancy).

If you would like more copies of this referral form, please visit BC Cancer's Health Professionals page at: www.screeningbc.ca/health-professionals.

STEP 1 Patient Information (or affix label)

FIRST NAME	LAST NAME
PHN	OTHER HEALTH NUMBER (E.G. REFUGEE, MILITARY)
DATE OF BIRTH (YYYYMMDD)	SEX ☐ F ☐ M ☐ X
ADDRESS	CITY/TOWN PROVINCE POSTAL CODE
TELEPHONE NUMBER	ALTERNATIVE TELEPHONE NUMBER
BEST TIMES TO CALL (Select all that apply) ☐ Monday to Friday: 8AM - 5PM ☐ Other, specify: _____	PREFERRED LANGUAGE(S) ADDITIONAL NOTES

STEP 2 Confirm Eligibility

ELIGIBLE FOR LUNG SCREENING

To be referred to the Lung Screening Program for a risk assessment, a patient must be:

- 55 to 74 years of age;
- Currently smoking or have smoked in the past; and,
- Have a smoking history of 20 years or more.

☐ **MY PATIENT MEETS ALL OF THE ABOVE REFERRAL INCLUSION CRITERIA**

☐ **PREVIOUS CHEST CT?**

Previous Chest CT date (yyyy/mm/dd): _____

Previous Chest CT location: _____

Not everyone who meets the referral inclusion criteria will be eligible for the Lung Screening Program. Those who are eligible will be referred for a follow-up CT on the 1 year anniversary of their previous Chest CT, if applicable.

INELIGIBLE FOR LUNG SCREENING

A patient with the following should not be referred for lung screening:

- Have been diagnosed with lung cancer;
- Are under surveillance for lung nodules;
- Have had hemoptysis of unknown cause or unexplained weight loss of more than 5 kg in the past year*; or,
- Are currently undergoing diagnostic assessment, treatment or surveillance for life-threatening conditions (e.g. a cancer with a poor prognosis or on home oxygen therapy for severe lung disease as assessed by the referring physician).

* People with these symptoms should receive appropriate diagnostic investigation and consultation.

STEP 3 Referring Provider Information (or affix label)

REFERRING PROVIDER (NAME, ADDRESS, MSC#) MSC#	
PROVIDER TO RECEIVE RESULTS, IF DIFFERENT FROM ABOVE (NAME, ADDRESS, MSC#). **The program can only send results to ONE provider, either GP/NP or specialist, not both.** MSC#	
PROVIDER SIGNATURE	REFERRAL DATE (YYYYMMDD)

STEP 4 Fax Form to BC Cancer Lung Screening: **1-604-877-6115**

Patients will be contacted by a Navigator to confirm lung screening eligibility.