nova scotia health
Cancer Care Program

Fax referral to: 902-425-1183
or email to:
lungscreening@nshealth.ca

Lung Screening Program Referral Form

Please note: This program is intended for asymptomatic individuals at high risk of developing lung cancer. If your patient has lung cancer symptoms do not refer them to this program but complete standard diagnostic imaging requisitions as appropriate.

Patient Information

Patient Legal Name: Last:	First:	Middle:
Used Name:	DOB:(YYYY-MM-DD)	
Phone:	Alternate Phone:	
HCN:	Email Address:	
Civic Address: Steet/Apt:	City:	Postal Code:

Sex assigned at birth: ☐ M ☐ F ☐ X ☐ Intersex

Pronouns: ☐He/Him ☐She/Her ☐They/Them ☐He/They ☐She/They ☐They/She/He
☐Negm or Nekm ☐Iel or Ielle ☐I use a different language to self-identify
Interpreter Required: ☐ Y ☐ N

Additional Information

History of Chronic Obstructive Pulmonary Disorder (COPD)

- Previous diagnosis of COPD: ☐Yes ☐No ☐Unknown

History of Chest Computed Tomography (CT)

- Previous chest CT? ☐Yes ☐No ☐Unknown
- Date (YYYYMMDD) _____and location (I.E. hospital name) of previous chest CTs (if known)_____. ☐Out of province

History of prior malignancy

- ☐Yes Type and approximate date: _____
- ☐No

Please indicate if there is any additional information about your patient that would be helpful for the program staff to be aware of (e.g. low vision, hearing loss, anxiety):

Referral Criteria

Referring Provider (or affix label)	Primary Care Provider
First and Last Name:	First and Last Name:
Registration #:	Telephone #:
Telephone #:	Fax #:
Fax #:	
NS billing #:	
I am this patient's primary care provider ☐Yes ☐No	
☐This patient does not have a primary care provider	
Date of Request: YYYY-MM-DD	

The Primary Care Provider will be copied on all communications related to their patient's lung screening activity. The Referring Provider is asked to notify their patient's Primary Care Provider of this referral.

Screening with low-dose lung CT scan has risks, including:
- Potential for false positives causing undue anxiety
- Side effects from a lung biopsy: Depending on someone's test results, they may need to have a lung biopsy (where a very small piece of the lung is removed) or surgery. The possible side effects of the lung biopsy are bleeding, infection, or a collapsed lung. Surgery has other risks.
- Lung cancer screening will not find all cancers early.
- Morbidity and mortality related to investigation and treatment of screen-detected abnormalities.
- Overdiagnosis: specifically diagnosis and treatment of lung cancer that would not have become clinically significant in the patient's lifetime
- Extra radiation: although the amount of radiation is low, widespread use of CT is predicted to result in excess cancers. The breast and thyroid tissue is particularly susceptible. The risk of radiation-related cancer is higher at a younger age.

Patient must be:
☐50 – 74 years of age; and
☐A current OR former smoker who has smoked daily for 20 years or more
Please note: Everyone who meets initial referral criteria will be eligible for a formal lung cancer risk assessment and will be provided with lung cancer education and smoking cessation referral. People at very high risk of lung cancer (based on formal risk assessment) will be eligible for LDCT screening and nicotine replacement therapy.– see FAQ/PCP Tool/Provider Guide

A patient should **NOT** be referred to the program if they:
- Have a previous history of lung cancer in the last five years.
- Have possible symptoms of lung cancer such as: persistent unexplained new cough or change in cough, unexplained weight loss of more than 15 pounds in the preceding year, and/or coughing up blood. These patients require urgent clinical evaluation.
- Have a serious medical condition with a life expectancy of less than five years.
- Patient unable to understand the risks (including morbidity of diagnostic and therapeutic procedures and concept of overdiagnosis) and benefits of screening and/or does not have the capacity to provide consent. Proxy decision making will be considered. Where there is uncertainty, considerations can be made on a case by case basis.

☐ My patient meets all of the above referral inclusion criteria

If your patient is eligible for CT screening based on a risk assessment, by signing this form as the referring health care provider, you:

- authorize the use of low-dose computed tomography (LDCT) for your patient's baseline scan, ongoing routine annual screening, and follow-up of nodules, according to evidence and leading practice, and in accordance with the patient's wishes
- authorize your patient's referral for smoking cessation, if appropriate
- authorize your patient's referral for lung diagnostic assessment, if recommended by the reporting radiologist
- authorize the Nova Scotia Lung Cancer Prevention and Early Detection program to facilitate the booking of LDCT scans
- confirm that you are responsible for ensuring appropriate follow-up of incidental findings

Signature: _____
Date (YYYYMMDD): _____

Fax referral to: 902-425-1183
Telephone #: 1- 833-505-5864
Email: lungscreening@nshealth.ca
Website: www.nshealth.ca/lungscreening

NOTE: Please inform the patient of this referral and note that the wait times for this program reflect the non-urgent nature of the assessment. Please inform the patient to seek urgent medical attention for signs and symptoms of lung cancer.