

Ontario Lung Screening Program (OLSP) Referral Form

- You may submit this referral to any of the eligible OLSP locations listed at ontariohealth.ca/lungscreeninglocations.
- Participants in the OLSP who have changed providers should complete Sections 1, 4, 5, 6.
- Not everyone who meets the referral inclusion criteria will be eligible for lung cancer screening in the OLSP (see Frequently Asked Questions).

1. PATIENT INFORMATION (OR AFFIX LABEL)			
First Name:		Last Name:	
Date of Birth (YYYY/MM/DD):		Address (Including Postal Code):	
Telephone Number:	Alternate Telephone Number:	OHIP Number:	Version Code:
2. REFERRAL CRITERIA			
To refer someone who is age 55 or older for an OLSP risk assessment for the first time, someone who self-presented or someone who was previously determined to be ineligible for the OLSP, they must: - have a smoking history of <u>any</u> amount of cigarettes daily for 20 years - have OHIP coverage ☐ The patient meets above criteria and none of the exclusion criteria		To refer a previous participant who is now over age 80 to continue screening in the OLSP, they must: - have discussed continuing lung screening with you - are well enough to undergo and recover from lung cancer treatment - have a lifespan (i.e. over 5 years) to benefit from treatment - have OHIP coverage ☐ The patient meets above criteria and none of the exclusion criteria	
EXCLUSION CRITERIA – Someone should not be referred to the OLSP if they: - have been diagnosed with lung cancer or are actively under surveillance for lung nodules - have had hemoptysis of unknown cause or unexplained weight loss of more than 5 kg (11 lbs) in the past year - are undergoing diagnostic assessment, treatment or surveillance for life-threatening conditions (e.g., a cancer with a poor prognosis)			
3. PATIENT HISTORY			
Previous Diagnosis of COPD? ☐ Yes ☐ No ☐ Unknown Previous Chest CT? ☐ Yes ☐ No ☐ Unknown (If Yes, provide date (YYYY/MM/DD) and location (i.e., hospital name) for up to two most recent chest CTs) 1. _____ 2. _____ Please provide any additional information or any accommodations required (e.g., low vision, hearing loss, designate support person, interpreter required).			
4. REFERRING PROVIDER (OR AFFIX LABEL)			
First and Last Name:		CPSO or CNO Number:	
Telephone Number:		Fax Number:	
I am the patient's primary care provider ☐ Yes ☐ No ☐ Patient does not have a primary care provider (If No, complete section 5, otherwise, skip section 5)			
5. PRIMARY CARE PROVIDER: The patient's primary care provider will be copied on all communications related to their lung cancer screening activity. However, you are asked to notify the patient's primary care provider of this referral.			
First and Last Name:		Telephone Number:	Fax Number:
6. SIGNATURE			
If the patient is eligible for screening based on a risk assessment and you sign this form as the referring health care provider, you: - authorize the use of low-dose computed tomography (LDCT) for the patient's baseline scan, ongoing routine annual screening and follow-up of nodules, according to OLSP guidance - authorize the patient's referral for lung diagnostic assessment, if recommended by the reporting radiologist confirm that you are responsible for ensuring appropriate follow-up of incidental findings			
Signature:		Date (YYYY/MM/DD):	