Ontario Lung Screening Program (OLSP) Referral Form

Ontario Health
Cancer Care Ontario

- You may submit this referral to any of the eligible OLSP locations listed at cancercareontario.ca/lungscreeninglocations.
- **Health Sciences North OLSP site fax: 705-523-7306**
- 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 any amount of commercial tobacco (i.e., cigarettes, cigars, loose tobacco, pipes or bidi/beedi) 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)

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