Ontario Health
Cancer Care Ontario

Ontario Lung Screening Program (OLSP) Referral Form

- You may submit this referral to any of the eligible OLSP locations listed at ontariohealth.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: First Name	Last Name: Last Name
Date of Birth (YYYY/MM/DD): Date of Birth (YYYY/MM/DD)	Address (Including Postal Code): Address
Telephone Number: Telephone Number	Alternate Telephone Number: Alternate Telephone Number
OHIP Number: OHIP Number	Version Code: 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 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. Previous Chest CT Date and Location #1
2. Previous Chest CT Date and Location #2

Please provide any additional information or any accommodations required (e.g., low vision, hearing loss, designate support person, interpreter required).

Additional Information or Accommodations

4. REFERRING PROVIDER (OR AFFIX LABEL)

First and Last Name: First and Last Name	CPSO or CNO Number: CPSO or CNO Number
Telephone Number: Telephone Number	Fax 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: First and Last Name	Telephone Number: Telephone Number	Fax 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): Date (YYYY/MM/DD)