National Lung Cancer Screening Program Imaging Request Form

Gibraltar radiology

The low-dose CT (LDCT) scan is fully funded under Medicare however your doctor may charge a consultation fee for the request and any follow up required.

PATIENT DETAILS

Name: .... DOB: ....

Address: ....

Phone: .... Medicare Number: ....

Aboriginal and/or Torres Strait Islander origin: ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Straight Islander

☐ Yes, both Aboriginal and Torres Straight Islander ☐ Prefer not to answer

CLINICAL INFORMATION

☐ This patient meets the eligibility criteria of the National Lung Cancer Screening Program

Type of screening test:

☐ **2 yearly scan:** ☐ New participant **OR** ☐ Participant returning for two-year scan

☐ **Interval scan** to monitor previous findings

☐ 1 ☐ 2 ☐ 3 ☐ 6 ☐ 9 ☐ 12 month interval scan as determined in previous NLCSP LDCT report

☐ **Any previous chest CT** Date (if known): ....

Radiology provider/location (if known): ....

☐ **Family history of lung cancer in a first-degree relative**
(i.e. parents/siblings/children - only required for first/baseline LDCT)

History of any cancer ☐ No ☐ Yes, (if yes, please provide details)

Additional clinical/other notes:

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☐ **Referring Practitioner has registered the patient via the NCSR**

Your personal information, including results of low-dose CT scans and other CT imaging completed for the purposes of screening as part of the NLCSP, may be shared between your treating healthcare providers for the purposes of the NLCSP. For example, if you attend different radiology providers for your first low-dose CT scan and your second low-dose CT scan, the first radiology provider may disclose your low-dose CT images to the second radiology provider to facilitate comparison of the results of the two low-dose CT scans. By participating in the NLCSP, you consent to the use of your personal information by healthcare providers, specialists and radiologists, for the purposes of the program, and the disclosure and collection of your personal information between healthcare providers, specialists and radiologists for the purposes of the program.

REFERRER DETAILS

Name: Provider Number:

Address: Phone:

Copy To: Fax:

Signature: Date: