

POST or FAX this FORM to ONLY ONE of the Lung Cancer Rapid Access Services to avoid duplication. (Please ✓)

- | | | | | |
|--|-----------------------------|---------------------|--|---------------------------------------|
| <input type="checkbox"/> Beaumont Hospital, Dublin 9 | Tel: (01) 809 2544 | Fax: (01) 797 4780 | <input type="checkbox"/> Mid Western Regional Hospital, Limerick | To open mid 2010 |
| <input type="checkbox"/> Cork University Hospital, Cork | Tel: (021) 492 0189 | Fax: (021) 492 2391 | <input type="checkbox"/> St. James's Hospital, Dublin 8 | Tel: (01) 416 2196 Fax: (01) 410 3549 |
| <input type="checkbox"/> Galway University Hospital | To open in mid 2010 | | <input type="checkbox"/> St. Vincent's University Hospital, Dublin 4 | Tel: (01) 221 3702 Fax: (01) 221 3576 |
| <input type="checkbox"/> Mater University Hospital, D. 7 | Tel: (01) 803 2644/803 2295 | Fax: (01) 803 4036 | <input type="checkbox"/> Waterford Regional Hospital, Waterford | Tel: (051) 848 988 Fax: (051) 848 844 |

Patient Details

Surname: _____
 First Name: _____ DOB: _____
 Address: _____

 Mobile No: _____ Tel day: _____
 Tel evening: _____
 Hospital No. (if known): _____
 First language: _____ Interpreter required: Yes No
 Gender: Male Female Wheelchair assistance: Yes No

General Practitioner Details

Name: _____
 Address: _____

 Telephone: _____ Mobile: _____
 Fax: _____
 GP Signature: _____ Date of referral: _____
 Medical Council Registration No.: _____

Referral Information

Main indications for referral are an **abnormal chest x-ray** or **haemoptysis**.

SYMPTOMS

Haemoptysis

Other persistent unexplained symptoms

SMOKING STATUS

Current smoker Ex smoker Non smoker

CLINICAL EXAMINATION

Clubbing Chest signs (please specify) _____
 Lymphadenopathy _____
 Hepatomegaly _____
 Other _____

Chest X-ray

Date of Chest X-Ray
 Hospital
 Normal
 Abnormal (suggestive of lung cancer)
Please attach/fax copy of result if possible

CT Scan (if done)

Date of CT Scan
 Hospital
 Normal
 Abnormal (suggestive of lung cancer)
Please attach/fax copy of result if possible

Past medical history:

Asthma Renal Insufficiency
 Other details: _____

Allergies: Yes No
 Details: _____
 History of allergy to contrast dye

Anticoagulants: Yes No
 Details: _____

Medications:

Comments:

Has patient been advised of possible diagnosis of lung cancer? Yes No

FOR HOSPITAL USE:

Date of referral received: _____
 Date of appointment offered: _____
 Reason patient did not accept first appointment offered: _____

Seen within Guidelines:
 Yes
 No

Lung Clinic Triage

Urgent Referral (to be seen within 2 weeks)
 Early Referral (to be seen within 6 weeks)
 Routine Referral (to be seen within 12 weeks)
 Triage by: _____