NATIONAL LUNG CANCER RAPID ACCESS SERVICE REFERRAL FORM

National Cancer Control Programme

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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

☐ Beamount Hospital, Dublin 9	Tel: (01) 809 3484	Fax: (01) 809 3488
☐ Cork University Hospital, Cork	Tel: (021) 492 0453	Fax: (021) 492 2391
☐ Galway University Hospital	Tel: To be advised	Fax: (091) 542 092
☐ Mater University Hospital, D. 7	Tel: (01) 803 2644/2295	Fax: (01) 803 4036
☐ Mid Western Regional Hospital, Limerick	Tel: (061) 585 637	Fax: (061) 482 572
☐ St. James's Hospital, Dublin 8	Tel: (01) 416 2196	Fax: (01) 410 3549
☐ St. Vincent's University Hospital, Dublin 4	Tel: (01) 221 3702	Fax: (01) 221 3576
☐ 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

☐ Lymphadenopathy

☐ Hepatomegaly

☐ Other _____

☐ Chest signs *(please specify)*

_____

_____

Chest X-ray

Date of Chest X-Ray _____

Hospital _____

Please attach/fax copy of result if possible

☐ Normal

☐ Abnormal

If abnormal, please comment

_____

CT Scan *(if done)*

Date of CT Scan _____

Hospital _____

Please attach/fax copy of result if possible

☐ Normal

☐ Abnormal

If abnormal, please comment

_____

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 receipted: _____

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)*

☐ Routine Referral *(divert to respiratory clinic)*

Triaged by: _____

Additional forms can be obtained by ringing the NCCP on (01) 8287100 or at www.cancercontrol.hse.ie