

Alberta Lung Cancer Screening Program (ALCSP) Referral

■ Please complete the form and fax (1-888-944-3388) it to Screening Programs

■ Contact the **Alberta Lung Cancer Screening Program** for more information:

Phone: 1-866-727-3926

Email: alcsp@ahs.ca

For additional resources, visit www.screeningforlife.ca

Last Name <i>(Legal)</i>		First Name <i>(Legal)</i>	
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB <i>(dd-Mon-yyyy)</i>	
PHN	ULI <input type="checkbox"/> Same as PHN	MRN	
Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary/Prefer not to disclose (X) <input type="checkbox"/> Unknown			

Patient Information	Physician/NP Information <i>(please use Stamp)</i>
Date Of Referral <i>(dd-Mon-yyyy)</i>	PCN/Practice Location
Address	Stamp Here
Phone number	
Cell number	
Email Address	Referring Prac ID

Referral Criteria

To be referred to the ALCSP for risk assessment, an individual must:

- Be 50 to 74 years old
- Currently smoke or have previously smoked with at least 15 pack-years of exposure

The ALCSP uses a risk-based approach to lung cancer screening. Upon receipt of referral, the program will calculate the individual's risk. Those with a lung cancer risk of greater than or equal to 1.5% will be invited for screening

Don't refer to the ALCSP if

In the opinion of the referring physician, the individual has a life expectancy of less than 10 years or significant comorbidities that would preclude aggressive treatment if lung cancer were detected. Examples may include but are not limited to:

- Prior invasive cancer diagnosis active or present in the past 5 years
- Severe heart or lung disease (NYHA III-IV, MMRC grade 3-4, requiring home oxygen).
- ECOG II-IV
- Chest symptoms requiring evaluation or chest CT in the past 12 months

The demographic information collected below is used to calculate lung cancer risk and program eligibility. It will be used exclusively for this purpose and monitoring program implementation. Individuals may elect not to provide certain information and still be referred to the program. This may result in underestimating their personal risk and may impact their eligibility for screening.

Ethnicity (voluntary) – self-identification by patient *(Select all that apply)*

- ☐ White ☐ Black ☐ First Nations (Status or non-status) ☐ Métis ☐ Inuit
☐ Additional Indigenous Identity ► Info: _____ Asian ► ☐ South, ☐ Southeast, ☐ East
☐ Middle Eastern ☐ Latin American ☐ Unknown ☐ Not disclosed/Provided ☐ Other: _____

Education

- ☐ 1 = Less than high school ☐ 2 = High school graduate ☐ 3 = Post high school training
☐ 4 = Some university ☐ 5 = University graduate ☐ 6 = Postgraduate

Patient Language _____ ☐ Interpretation/Translation Required

Comorbidities ☐ Known COPD, emphysema or chronic bronchitis ☐ Personal history of cancer
☐ Family History of lung cancer *(1st degree relative)*

Weight & Height Weight _____ (kg/lbs) Height _____ (cm/ft-in)

Smoking Status ☐ Active cigarette use in past year ☐ Quit: _____ (#) years since quitting

Average number of cigarettes smoked per day over entire period smoked _____ (#) per day

Total duration smoked, even if not continuous _____ (#) years

Shared decision making to proceed with low-dose CT (LDCT) lung cancer screening

☐ This patient meets all the above referral inclusion/exclusion criteria and consents to a referral for lung cancer screening; please request LDCT examination if the criteria for screening are met.

Ordering MD / NP Name _____ Ordering MD / NP Signature _____ Date *(dd-Mon-yyyy)* _____