DO NOT PLACE LABEL ABOVE LINE

BC CANCER LUNG SCREENING Provincial Health Services Authority

REFERRAL UPDATE FORM

AFFIX CLIENT LABEL HERE

PRESS FIRMLY TO ENSURE LEGIBILITY

FAX TO LUNG SCREENING PROGRAM: 1 (604) 297-9340

REFERRAL DATE (YYYYMMDD) | COMPLETED DATE (YYYYMMDD) | PATIENT NAME LAST | PATIENT NAME FIRST | SEX (F|M|X) X

FACILITY NAME | AMENDED DATE (YYYYMMDD) | PHN | DATE OF BIRTH (YYYYMMDD)

PRIMARY PROVIDER (MSC) | PRIMARY PROVIDER LAST, FIRST

COMPLETE ONLY ONE SECTION BELOW

☐ **SECTION A: TRANSFER REQUEST** *Complete only if referral requires transfer to another Medical Imaging (CT scan) facility*

Transfer Request To: _____

(Name of Medical Imaging Facility or Hospital)

Reason:
☐ Medical Reason ☐ Patient Preference ☐ Patient Address Related
☐ No Appointment Availability ☐ Requested Service(s) Not Available
☐ Other (Please specify): _____

☐ **SECTION B: PATIENT NOT PROCEEDING** *Complete only if patient is not proceeding for further follow up at your facility.*

Please ensure the patient's primary provider has been notified if the patient is not going to proceed.

☐ Patient declined follow up
☐ Patient was not able to be contacted
☐ Patient moved out of province
☐ Patient is medically unfit for follow up
☐ Patient went to a different facility for follow up. Facility Name (if known): _____
☐ Patient is deceased
☐ Other: _____

COMPLETED BY | SIGNATURE