Australian Government

HEALTHCARE PROVIDER SPECIALIST REFERRAL FORM

NATIONAL LUNG CANCER SCREENING PROGRAM

What is this form for

This form is to provide the National Cancer Screening Register (NCSR) with information regarding your patient when they are referred to a specialist, based on the results and details.

Filling in this form

- Fill in all mandatory fields marked with an asterisk (*).
- Use a black or blue pen and write in BLOCK LETTERS.

Submitting this form

Electronic	To complete this form electronically, access it via your integrated Clinical Information Software or the NCSR Healthcare Provider Portal. For assistance accessing the Healthcare Provider Portal, call **1800 627 701**. You can also book a time to receive a call back: www.ncsr.gov.au/support
Hardcopy	Access this form at www.ncsr.gov.au/lung/healthcare-providers **Return it via:** • **Free fax:** 1800 154 854 • **Mail to:** National Lung Cancer Screening Program Reply Paid 94632 SUNSHINE VIC 3020

Privacy

In accordance with the relevant requirements of the Privacy Act 1988 (Cth), patients are made aware that healthcare providers may collect and disclose their personal information to the NCSR. You are authorised to collect and disclose your patient's personal information under the National Cancer Screening Register Act 2016.

The NCSR is authorised to collect information about you and other healthcare providers from Services Australia and others for the purpose of verifying your identity and communicating with you. The NCSR also collects information directly from you. Your personal information may be disclosed to a range of agencies or organisations, including State and Territory Health Departments, Australian Government agencies and where you have agreed or where it is authorised or required by law or court or tribunal order.

For further information on the NCSR privacy policy, visit www.ncsr.gov.au/privacy.

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1 Patient details

Please provide patient details below

Medicare or DVA number *

Family name *

Given name(s) *

Date of birth * (DD/MM/YYYY) / /

Gender * ☐ Male ☐ Female ☐ Other

Postal address *

Suburb / Town / City *

State / Territory * Postcode *

Is your patient of Aboriginal or Torres Strait Islander origin? *

☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Prefer not to answer

What is your patient's country of birth? *

What is your patient's preferred language spoken at home? *

Does your patient need an interpreter service to understand English? * ☐ Yes ☐ No

2 Specialist referral details

Please complete the following details for the lung specialist to whom you are referring your patient.

What date did you refer the patient? * (DD/MM/YYYY) / /

Specialist provider number

Specialist family name *

Specialist given name

Name of facility / hospital

Specialist provider contact number

3 Provider details

Write your name and provider number OR place your stamp in the box.

Provider number *

Family name *

Given name

Work telephone

Mobile telephone

Are you operating in an Aboriginal Community Controlled Health Organisation? * ☐ Yes ☐ No

Provider stamp