Australian Government

DIAGNOSIS FORM

NATIONAL LUNG CANCER SCREENING PROGRAM

What is this form for

Use this form to provide the National Cancer Screening Register (NCSR) with details regarding your patient's diagnosis and other clinical information following their referral to a specialist based on Low-Dose CT results.

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 *

2 Provider details

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

Provider number *

Family name *

Given name

Provider stamp box

3 Clinical and diagnosis details

Please provide the clinical details of the patient along with the cancer diagnosis information.

First date of appointment with patient (DD/MM/YYYY) / /

Date of clinical diagnosis * (DD/MM/YYYY) / /

Case discussed at Multi Disciplinary Team (MDT) meeting? ☐ Yes ☐ No

MDT name

MDT hospital name

Cancer status *

- ☐ Benign or inflammatory (no evidence of cancer)
- ☐ Primary lung cancer (evidence of Cancer)
- ☐ Unknown
- ☐ Secondary lung or other cancer
- ☐ Not stated / inadequately described

Diagnosis findings *

- ☐ Small cell carcinoma
- ☐ Large cell carcinoma
- ☐ Metastatic malignant neoplasm (metastasis FROM the lung)
- ☐ Non-small cell carcinoma
- ☐ Other specified carcinoma & unspecified malignant neoplasms
- ☐ Benign / reactive lung lesions
- ☐ Squamous cell carcinoma
- ☐ Precursor lung lesions
- ☐ Unsatisfactory / non-diagnostic
- ☐ Adenocarcinoma
- ☐ Secondary lung carcinoma (metastasis TO the lung)

Details of carcinoma

Stage at diagnosis

- ☐ 0
- ☐ I
- ☐ II
- ☐ III
- ☐ IV
- ☐ V
- ☐ Stage unknown
- ☐ Inadequately described

Clinical comments