Australian Government

PARTICIPATION MANAGEMENT FORM

NATIONAL LUNG CANCER SCREENING PROGRAM

What is this form for

This form is used to update the National Cancer Screening Register (NCSR) with details of the patient's follow-up visit after receiving LDCT results, ensuring appropriate management within the National Lung Cancer Screening Program.

When to use this form

Healthcare providers must submit this form after a patient's post-LDCT consultation to update the NCSR with screening outcomes and inform the next steps in the screening pathways.

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 Eligibility and participation

IMPORTANT: Only complete this question if your patient is exiting the program

Has the patient become ineligible during the course of their participation in the program, withdrawn during consult, or received a cancer diagnosis?

☐ Has become ineligible

☐ Patient withdrew during consult (opt out)

☐ Diagnosed with primary lung cancer

☐ Diagnosed with secondary lung cancer

If Yes to any of the above, go to Section 4 – Provider details

Your patient may have temporary criteria preventing a low-dose CT (LDCT) scan such as but not limited to:

- Weight exceeds restrictions of CT scanner (200kg).
- Unable to lie flat and hold hands above head for the scan.
- Intercurrent lung condition e.g. pneumonia or bronchitis.
- Full thoracic CT scan within last 12 months or planned for clinical reasons in the next 3 months.
- If an intercurrent lung condition is present the LDCT scan must be delayed a minimum of 12 weeks.

Is your patient suitable for LDCT? *
If yes, go to section 3 – Smoking cessation

☐ Yes ☐ No

If your patient is temporarily unsuitable for an LDCT scan, please nominate a date for when they will resume screening and receiving NCSR reminders. If no date is selected the patient will need to have their participation in the National Lung Cancer Screening Program resumed by their healthcare provider in order to receive NCSR reminders.

Date patient can resume screening (DD/MM/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

3 Smoking cessation

Please provide smoking cessation support information:

Has smoking cessation support been offered to your patient? ☐ Yes ☐ No ☐ N/A (former smoker)

If 'Yes', what type of smoking cessation support has been offered? (Please check all that apply)

☐ Referral to Quitline
☐ Comprehensive intervention led by GP
☐ Pharmacological management e.g. Varenicline
☐ Brief intervention led by GP
☐ Scheduled another appointment to discuss
☐ Other – *Please specify below*

Other type of smoking cessation support offered: _____

4 Provider details

Write your name and provider number OR place your stamp in the box. Complete the date of consultation.

Provider number *

Family name *

Given name

Work telephone Mobile telephone

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

Date of consultation * (DD/MM/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

Provider stamp box