

UR No: _____
Surname: _____
Given Name: _____
DOB: _____

St Vincent's Specialist Clinics Referral Form – National Lung Cancer Screening Program

FAX this form to: (03) 9231 3489. Urgent (03) 9231 2910

Specialist Clinics – Daly Wing, 35 Victoria Parade, Fitzroy - Phone: 9231 2898

If urgent, phone the relevant Case Coordinator Nurse via switchboard phone: 9231 2211

GP Details:

Name: _____
Provider Number: _____
Practice Name: _____
Practice Address: _____
Phone: _____ Fax: _____

Patient Details:

St Vincent's UR No (if known): _____
Surname: _____
Given Name: _____
Date of Birth: _____
Address: _____
Home phone: _____ Mobile phone: _____
Interpreter Required: ☐ No ☐ Yes - Language: _____
Medicare No: _____

Specialty Required: All Respiratory and Actionable findings requiring Specialty follow up from LDCT as a part of the National Lung Cancer Screening Program.

☐ National Lung Cancer
Screening Program

Clinic name (If known): _____

Reason for Referral and Current Medical Problems:

Relevant Past Medical History:

Current Medications and Dosage:
Relevant investigations and results (Please include date, location and imaging facility of LDCT): (Please attach copies)

Referral valid for: ☐ 12 months ☐ 3 months (specialist referral) ☐ Indefinite

Signature: _____

Date: _____

GPs please note:

Ensure your practice details are up-to-date in the National Health Services Directory.

We rely on this to send letters about your patient’s care.

To update: Phone: (02) 9263 9092 or email: nhsd@healthdirect.org.au

Please consult [HealthPathways Melbourne](#) for assessment, management and referral guidance on clinical presentations - Username: connected / Password: healthcare