William Osler Health System

CT

Department of Diagnostic Imaging

Brampton Civic Hospital **Etobicoke General Hospital**
Corporate Patient Navigator **Phone:** 905-494-6628
Fax: **905-494-6524**

Name: _____
Address: _____
City: _____ Postal Code: _____
Health Card No.: _____
Date of Birth: (DD/MM/YYYY): _____
Telephone #: _____

Acc # _____
_____

BCH ☐ **EGH** ☐

Appointment Date: _____ Time: _____

Please fax all requisitions to Corporate Navigator. Appointment will be given by telephone or mail notification.

Early Detection of Lung Cancer Examination

Low Dose Chest CT

Patient Eligibility Requirements:

☐ **Age 55-77**

☐ **> 30 Pack-Year Smoking History**

Does your patient wish to participate in a smoking cessation program?
Yes ☐ **No** ☐

Prior CT chest: Yes ☐ **No** ☐ If **Yes:** date, location of last chest CT: _____

1) Current smoker	**YES** ☐	**NO** ☐	If **No**, indicate date quit: _____
2) Repeated exposure to second hand smoke	**YES** ☐	**NO** ☐	
3) Exposure to asbestos	**YES** ☐	**NO** ☐	
4) History of tuberculosis	**YES** ☐	**NO** ☐	
5) Previous diagnosed lung disease (Eg. asthma, emphysema, bronchitis, recurrent pneumonia)	**YES** ☐	**NO** ☐	If **Yes**, indicate _____
6) Cough / wheezing / shortness of breath	**YES** ☐	**NO** ☐	
7) Coughing blood	**YES** ☐	**NO** ☐	
8) Unexplained weight loss	**YES** ☐	**NO** ☐	
9) Family history of lung cancer	**YES** ☐	**NO** ☐	

Incomplete Requisitions will be returned for completion

Physician Name (Print) _____ Telephone _____

Physician Signature _____ Date _____