

**POST or FAX this FORM to ONLY ONE of the Lung Cancer Rapid Access Services to avoid duplication. (Please ✓)**

- |  |                         |  |  |                    |                    |
|--|-------------------------|--|--|--------------------|--------------------|
| <input type="checkbox"/> Beaumont Hospital, Dublin 9     | Tel: (01) 809 3484      | <input type="checkbox"/> Mid Western Regional Hospital, Limerick | Tel: (061) 585 637   | Fax: (061) 482 572 |                    |
| <input type="checkbox"/> Cork University Hospital, Cork  | Tel: (021) 492 0453     | Fax: (021) 492 2391  | <input type="checkbox"/> St. James's Hospital, Dublin 8              | Tel: (01) 416 2196 | Fax: (01) 410 3549 |
| <input type="checkbox"/> Galway University Hospital      | Tel: (091) 542 234      | Fax: (091) 542 092   | <input type="checkbox"/> St. Vincent's University Hospital, Dublin 4 | Tel: (01) 221 3702 | Fax: (01) 221 3576 |
| <input type="checkbox"/> Mater University Hospital, D. 7 | Tel: (01) 803 2644/2295 | Fax: (01) 803 4036   | <input type="checkbox"/> Waterford Regional Hospital, Waterford      | Tel: (051) 848 988 | Fax: (051) 848 844 |

### Patient Details

Surname: \_\_\_\_\_  
 First Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Mobile No: \_\_\_\_\_ Tel day: \_\_\_\_\_  
 Tel evening: \_\_\_\_\_  
 Hospital No. (if known): \_\_\_\_\_  
 First language: \_\_\_\_\_ Interpreter required: Yes  No   
 Gender: Male  Female  Wheelchair assistance: Yes  No

### General Practitioner Details

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 GP Signature: \_\_\_\_\_ Date of referral: \_\_\_\_\_  
 Medical Council Registration No.: \_\_\_\_\_

### Referral Information

Main indications for referral are an **abnormal chest x-ray** or **haemoptysis**.

#### SYMPTOMS

Haemoptysis

#### Other persistent unexplained symptoms

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

#### SMOKING STATUS

Current smoker  Ex smoker  Non smoker

#### CLINICAL EXAMINATION

Clubbing  Chest signs (please specify) \_\_\_\_\_  
 Lymphadenopathy \_\_\_\_\_  
 Hepatomegaly \_\_\_\_\_  
 Other \_\_\_\_\_

#### Chest X-ray

Date of Chest X-Ray: \_\_\_\_\_ Please attach/fax copy of result if possible  
 Hospital: \_\_\_\_\_  
 Normal  
 Abnormal If abnormal, please comment  
 \_\_\_\_\_

#### CT Scan (if done)

Date of CT Scan: \_\_\_\_\_ Please attach/fax copy of result if possible  
 Hospital: \_\_\_\_\_  
 Normal  
 Abnormal If abnormal, please comment  
 \_\_\_\_\_

#### Past medical history:

Asthma  Renal Insufficiency  
 Other details: \_\_\_\_\_

#### Allergies: Yes No

Details: \_\_\_\_\_  
 History of allergy to contrast dye

#### Anticoagulants: Yes No

Details: \_\_\_\_\_

#### Medications:

#### Comments:

**Has patient been advised of possible diagnosis of lung cancer?**

Yes  No

#### FOR HOSPITAL USE:

Date of referral received: \_\_\_\_\_  
 Date of appointment offered: \_\_\_\_\_  
 Reason patient did not accept first appointment offered: \_\_\_\_\_

Seen within Guidelines:  
 Yes   
 No

#### Lung Clinic Triage

Urgent Referral (to be seen within 2 weeks)  
 Routine Referral (divert to respiratory clinic)

Triaged by: \_\_\_\_\_