

B.C. Lung Screen Trial Referral Form

Fax Number: 604-675-8098

Surname: _____		First Name(s): _____		Gender: <input type="radio"/> M <input type="radio"/> F	
Birth Date: _____ / _____ / _____		Age: _____ yrs		PHN: _____	
Day / Month / Year					
Current Height: _____ inches (OR) _____ cm		Current Weight: _____ lbs (OR) _____ kg			
Mailing Address: _____			Email: _____		
Daytime Phone: (_____) _____			Alternate phone: (_____) _____		

Note: The information you provide is very important but, you may refuse to answer any question(s) you find inappropriate

1) Doctor: _____	MSP#: _____	Phone: _____
Doctor Address: _____	Fax: _____	

2) What ethnicity do you consider yourself to be?

<input type="radio"/> Aboriginal (e.g. First Nations, Métis, Inuit)	<input type="radio"/> Latin American/Hispanic
<input type="radio"/> Middle Eastern (e.g. Turkey, Iran, Afghanistan, Egypt, Iraq, Jordan, Lebanon)	<input type="radio"/> South Asian (e.g. India, Sri Lanka, Pakistan, Bangladesh)
<input type="radio"/> African or Caribbean descent	<input type="radio"/> Southeast Asian (e.g. Malaysia, Indonesia, Vietnam)
<input type="radio"/> Caucasian	<input type="radio"/> East Asian (e.g. China, Japan, Korea, Taiwan)
<input type="radio"/> Filipino	<input type="radio"/> Other ethnic group not listed above, please specify: _____
<input type="radio"/> Jewish	

3) How old were you when you started smoking cigarettes regularly? _____ yrs old

4) Are you still smoking now?

YES: If you are still smoking now, were there times longer than a year when you did not smoke?

Yes No If YES for how many years? _____ yrs

NO: Between the time you started smoking and finally quit smoking, were there periods longer than a year when you did not smoke?

Yes No If YES for how many years? _____ yrs

5) If you are not currently smoking, how old were you when you stopped? _____ yrs old

6) On average, when you smoke(d), how many cigarette(s) a day do/did you smoke? _____ cigs/day

7 a)	Have you ever been diagnosed with any cancer(s)? Do not include cancers of the skin <i>other than</i> melanoma.	
	1. Ever <input type="radio"/> Yes <input type="radio"/> No	2. In the last 5 years <input type="radio"/> Yes <input type="radio"/> No
b)	Have you had any treatment for any type of cancer(s)? Do not include cancers of the skin <i>other than</i> melanoma.	
	1. In the last 5 years but not currently <input type="radio"/> Yes <input type="radio"/> No	2. Currently (that is, on active treatment now) <input type="radio"/> Yes <input type="radio"/> No
c)	Have you ever been diagnosed with lung cancer?	<input type="radio"/> Yes <input type="radio"/> No

8) Were any of your blood relatives (mother, father, children, siblings, including half-sisters and half-brothers) ever diagnosed with lung cancer? Yes No

9) What is the highest level of education you have completed?

<input type="radio"/> Grade 8 or less	<input type="radio"/> Grade 9 to Grade 11	<input type="radio"/> High School Graduate	<input type="radio"/> Technical/Vocational School Certificate
<input type="radio"/> Some College/University	<input type="radio"/> University Graduate	<input type="radio"/> Post Graduate/Professional Degree	

10) Have you had a CT scan of your chest within the last 2 years? Yes No

11) Has a physician ever told you that you have or had any of the following medical conditions?

COPD <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	Chronic Bronchitis <input type="radio"/> Yes <input type="radio"/> No
---	--	---