UVA Health

Referral for Lung Cancer Screening

Last Name_____ First Name_____

Phone number_____ DOB_____

UVA MRN (if known)_____ Insurance_____

Required Information to determine eligibility of lung cancer screening:

1. Is patient currently free from symptoms of cancer? ❑ YES
2. Is the patient between the ages of 50 - 77 with a 20-year history of smoking? ❑ YES
3. Is patient a current smoker? ❑ YES ❑ NO
   a. If no, when did the patient quit : _____
4. When did the patient start smoking? _____
5. On average, how many packs per day does (did) the patient smoke?

   _____

Referring Physician Signature:_____

Referring Physician Name (Print):_____

Referring Physician Phone Number/Email:_____

To Complete the Referral Process:

1. Fax this form to 434.244.7526
2. Upon Receipt of this form, a member of our team will review the referral and contact the patient to schedule a visit.
3. If you have any questions you may call 434.924.9333