

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 55 and 77? 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