Premier Health

Lung Node Evaluation Program Referral Form

Phone: (937) 208-9050
Fax: (937) 223-9804

Patient Name: _____

Patient Date of Birth: _____

Patient Phone Number: _____

Primary Care Provider Name: _____

Primary Care Provider Phone: _____

Primary Care Provider Fax: _____

Type of image lung nodule was found:

- ☐ CT
- ☐ CXR
- ☐ MRI

Date of Finding:_____

Facility Location of Testing: _____

Current or Former Smoker? _____

Personal or Family History of Lung Cancer? _____

Preference of Pulmonologist if Referral is Needed: _____