Australian Government

BIOPSY ADVERSE EVENTS FORM

NATIONAL LUNG CANCER SCREENING PROGRAM

What is this form for

Use this form to inform the National Cancer Screening Register (NCSR) of any adverse events arising from a biopsy procedure that your patient has undergone, following Low-Dose CT results.

Filling in this form

- Fill in all mandatory fields marked with an asterisk (*).
- Use a black or blue pen and write in BLOCK LETTERS.

Submitting this form

Electronic	To complete this form electronically, access it via your integrated Clinical Information Software or the NCSR Healthcare Provider Portal. For assistance accessing the Healthcare Provider Portal, call **1800 627 701**. You can also book a time to receive a call back: www.ncsr.gov.au/support
Hardcopy	Access this form at www.ncsr.gov.au/lung/healthcare-providers **Return it via:** • **Free fax:** 1800 154 854 • **Mail to:** National Lung Cancer Screening Program Reply Paid 94632 SUNSHINE VIC 3020

Privacy

In accordance with the relevant requirements of the Privacy Act 1988 (Cth), patients are made aware that healthcare providers may collect and disclose their personal information to the NCSR. You are authorised to collect and disclose your patient's personal information under the National Cancer Screening Register Act 2016.

The NCSR is authorised to collect information about you and other healthcare providers from Services Australia and others for the purpose of verifying your identity and communicating with you. The NCSR also collects information directly from you. Your personal information may be disclosed to a range of agencies or organisations, including State and Territory Health Departments, Australian Government agencies and where you have agreed or where it is authorised or required by law or court or tribunal order.

For further information on the NCSR privacy policy, visit www.ncsr.gov.au/privacy.

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1 Patient details

Please provide patient details below

Medicare or DVA number *

Family name *

Given name(s) *

Date of birth * (DD/MM/YYYY) / /

Gender * ☐ Male ☐ Female ☐ Other

Postal address *

Suburb / Town / City *

State / Territory * Postcode *

2 Adverse event information

Please provide the adverse event information associated with the biopsy procedure.

Type of biopsy performed *

☐ Needle (CT guided) ☐ Transbronchial ☐ Thoracoscopic ☐ Open biopsy

☐ Other – *please specify below*

Other type of biopsy performed: _____

Adverse outcomes *

☐ Blood loss or blood clots ☐ Pain or discomfort ☐ Infection ☐ Drug allergic reaction

☐ Pneumonia ☐ Reaction to sedation ☐ Pneumothorax ☐ Hemothorax

☐ Pulmonary haemorrhage (with/without haemoptysis) ☐ Air embolism ☐ Pleural effusion ☐ Other – *please specify below*

Other adverse outcomes: _____

Death * ☐ Yes ☐ No

Delayed discharge * ☐ Yes ☐ No

Surgery required * ☐ Yes ☐ No

Unplanned hospital admission within 30 days of procedure * ☐ Yes ☐ No

As page 3 may become separated from page 2, repeat patient Medicare/DVA number here:

Medicare or DVA number *

3 Provider details

Please provide the details of the provider and/or the facility where the biopsy procedure was performed OR place your stamp in the box.

Clinician / proceduralist surname *

Clinician / proceduralist given name

Name of facility / hospital *

Date of procedure * (DD/MM/YYYY) / /

Contact telephone number for questions regarding this form

Provider stamp box