

Patient Information

Order Date _____

Name _____

Phone _____ DOB _____

Height _____ Weight _____

Referring Provider Information

Name _____

Organization _____

Office Phone # _____ Fax # _____

After Hours Phone _____ CC Other Treating MD _____

Insurance Information

Insurance _____

Authorization # _____

When the Exam is Completed

- Urgent Preliminary Report (STAT) Phone consult with Radiologist
 Hold Patient Burn CD _____

Please notify us if relevant comparison films, reports or current labs are available.

**LUNG CANCER SCREENING WITH LOW DOSE CT (LDCT)
ORDER FORM**

Eligibility Criteria:

- * Age 50 - 77
- * Asymptomatic (no signs or symptoms of lung cancer)
- * Tobacco smoking history of at **least** 20 pack-years (one pack-year = smoking one pack per day for one year)
- * Current smoker or one who quit smoking within the last 15 years
- * Has undergone an **initial** counseling and shared decision-making visit

CT Chest Lung Screening Exam

Smoking history: (Required)

Packs/day (20 cigarettes/pack): _____ x Years Smoked: _____ = Pack Years: _____

Currently smoking? Yes No If no, number of years since quitting smoking? _____

Has the patient ever had lung cancer? Yes No Any other cancer? _____

By signing this order, you are certifying that:

- * The patient has participated in a shared decision-making session which potential risks and benefits of CT lung screening were discussed.
- * The patient was informed of the importance of adherence to annual screening, impact of comorbidities, and ability/willingness to undergo diagnosis and treatment.
- * The patient was informed of the importance of smoking cessation and/or maintaining smoking abstinence, including the offering of Medicare-covered tobacco cessation counseling services, if applicable.
- * The patient is asymptomatic (no symptoms such as fever, chest pain, new shortness of breath, new or changing cough, coughing up blood, or unexplained significant weight loss).

Ordering MD Signature: _____

Date: ____ / ____ / ____