ELECTRA MEMORIAL HOSPITAL

CT Low Dose Lung Screening Order Form

FAX TO (940) 298-1640

Patient Name: ____________________________ **MRN:** _____________________ **DOB:** ____/____/____

Packs/Day (20 cigarettes/pack): __________ **x Years Smoked:** ______________ **= Pack Years:** ______________

Currently Smoking? Y or N **If not currently smoking, how many years quit?** ______________

Must meet following criteria for screening: **Height:** __________ **Weight:** ___________

1) Age 55-77
2) Asymptomatic (no signs or symptoms of lung cancer
3) Tobacco smoking history of at least 30 pack-years
4) Current smoker or one who has quit within the last 15 years
5) Patient has not had a chest CT scan in the past year
6) Patient was offered tobacco cessation counseling
7) Patient was engaged in shared decision-making for this test

Ordering MD or NP (print name): ____

National Provider Identifier (NPI): ____

CT Lung Screening (check one): **Initial** _______ **Repeat** _______ **Follow-Up** ______

By signing this order, you are certifying that:

- The patient has participated in a shared decision-making session during 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 offer 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)

Please maintain this original order in patient's medical record and send a copy along with pink slips for pre-cert and scheduling

Ordering MD or NP signature ____ **Date:** _________________________