



CRESTWOOD MEDICAL CENTER

LDCT Lung Screening Order Form

Patient Name: _____ D.O.B. ___/___/___ Patient phone # _____

Pack/day _____ x Years smoked: _____ = **Pack years***: _____ Insurer _____

*pack year calculator: <http://smokingpackyears.com>

Currently smoking? Y N If not currently smoking, how many years since stopped? _____

CT Lung Screening Exam (please select one)

Diagnosis Code _____

___ INITIAL LUNG SCREENING EXAM (BASELINE) ___ SUBSEQUENT EXAM (ANNUAL)

Fax completed Lung Screening Order form to 256-429-4612

The patient must meet ALL of the following requirements for eligibility into the LDCT Lung Screening Program

The patient is between the ages of **50-77**

The patient is a current or former smoker with at **least** a 20 pack year history **AND** has smoked within the last 15 years.

The patient is asymptomatic for lung cancer (**patients that have symptoms of lung cancer should typically receive a diagnostic CT**). I attest the patient is not being treated for any of the following:

- Fever
- New or changing cough
- Significant chest pain
- Unintended weight loss
- Hemoptysis
- Active pneumonia

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 tobacco cessation consulting services, if applicable.

A one time shared decision-making session, discussing the risks and benefits associated with screening has been completed for initial scan only.

Ordering Provider Signature: _____ Date ___/___/___

By signing this order, you are attesting that the patient meets all of the above required elements and those elements are documented in the office notes

Ordering Provider (print name): _____ Phone: _____

Ordering Provider NPI**# _____ Fax: _____

**Provider NPI number required.