CT Lung Cancer Screening Order Form

Fax: 803-296-2969

PALMETTO HEALTH

Patient Name: _____ MRN: _____ DOB: _____

Insurance Provider: ☐ Medicare Others _____

Height: _____ Weight: _____ Gender: ☐ Male ☐ Female Age: _____

Packs/day (20 cigarettes/pack): _____ x Years smoked: _____ = Pack years*: _____

* Pack year calculator: http://smokingpackyears.com

Currently smoking? ☐ Yes ☐ No If not smoking, how many years quit? _____

☐ Initial Screening ☐ 12 month follow up screening ☐ 6 month follow up screening ☐ 3 month follow up screening

Counseling and Shared Decision Making Session Occurred:

- The patient has participated in a shared decision-making session during which benefits and potential risks of CT lung screening were discussed, as well as follow-up diagnostic testing, over-diagnosis, false positive rates and radiation exposure.
- 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).

Ordering MD (print name): _____ Phone: _____

National Provider Identifier (NPI): _____ Fax: _____

Ordering MD Signature: _____ Date: _____