LDCT LUNG SCREENING ORDER FORM

Please Choose Annual Screening or Follow-Up

PATIENT INFORMATION

Last Name: _____ First Name: _____
Phone: _____ DOB: _____

☐ FOLLOW-UP ORDER

Previous LungRads Received: _____ Date: _____ Recommended Follow-up Date: _____
Diagnosis Code: _____ Comments: _____

LungRads 4B or 4X

- ☐ PET Scan
- ☐ Chest CT w/o contrast
- ☐ Chest CT with contrast
- ☐ Biopsy
- ☐ Other

LungRads 4A (3 Month Recommendation)

- ☐ PET Scan
- ☐ Low Dose Chest CT
- ☐ Other

LungRads 3 (6 Month Recommendation)

- ☐ Low Dose Chest CT
- ☐ Other

☐ ANNUAL SCREENING ORDER

Currently smoking? Y / N ◉ YES ○ NO
Shared decision making? Y / N ◉ YES ○ NO
If not smoking, how many years quit? _____
Pack Years (must be minimum of 30. Pack years = packs per day x number of years smoked) _____

Exam:

☐ CT Lung Screening Exam

Diagnosis:

☐ Former Smoker

☐ Smoker

By signing this order, you are acknowledging the following eligibility for your patient:

☐ Between ages 55 and 80

☐ The patient was informed of the importance of smoking cessation and/or maintain smoking abstinence, and if appropriate, furnishing of information about tobacco cessation interventions.

☐ Asymptomatic (no symptoms of lung cancer)

☐ The patient has participated in a Shared Decision-Making session for their initial screening

PROVIDER INFORMATION

Ordering Provider: _____ NPI: _____
Fax: _____ Phone: _____
Insurance: _____ Authorization #: _____
Physician Signature: _____ Date: _____