

# LUNG CANCER SCREENING FORM

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female  
SSN: \_\_\_\_\_ Medicare Beneficiary Number: \_\_\_\_\_  
MRN: \_\_\_\_\_ Screening Year: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Physician NPI: \_\_\_\_\_  
Physician Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Physician's Phone #: \_\_\_\_\_ Physician's Fax #: \_\_\_\_\_  
Person Completing Form: \_\_\_\_\_ Insurance Contract #: \_\_\_\_\_

## PATIENT INFO:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Current Smoker:  Yes  No Former smoker, stopped smoking \_\_\_\_\_ years ago  
Smoking History: Smoked \_\_\_\_\_ packs per day for \_\_\_\_\_ years (must be > 30 pack/years)  
Chest CT Scan within the past year?  Yes  No  
Prior Personal History of Lung Cancer?  Yes  No

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 for acute pulmonary disease (no fever, no chest pain, no new or changing cough and no change in quantity /color of sputum).
- Yes  No The patient has signs or symptoms of lung cancer such as new shortness of breath, coughing up blood, new sputum production or significant unexplained weight loss. (If patient has a sign or symptom of lung cancer, a chest CT with contrast should be ordered, NOT a low-dose non-contrast lung cancer screening CT.)

Referring physicians: To schedule your patient for a lung screening appointment please call 205-801-8750 option 3 and fax this completed form to the UAB Access Center at 205-731-6479.

PHYSICIAN/PROVIDER SIGNATURE	DATE	TIME