



LUNG SCREENING DATA COLLECTION FORM AND ORDER

Patient Name: _____		Primary Phone: _____
Height: _____	DOB: _____MM/DD/YYYY	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Weight: _____	Age: _____	
Name of PCP: _____ Referring Physician: _____		

Cigarette Smoking Status

Current Smoker
Was information on smoking cessation offered to patient
Yes No Unknown
Former Smoker
How many years ago did you quit? _____ years

Pack Year Calculation

How many years have you/did you smoke? _____ years
How many packs/days do you/did you smoke? _____ packs
Calculated pack year history: _____

Health History

Family History of Lung Cancer Yes No Unknown

Personal History of Cancer Yes No Unknown
Type _____
 Diagnosis of COPD or Pulmonary Fibrosis N/A

Exposure History

- Radon exposure No Unknown
- Occupational exposures No Unknown
 - Asbestos Arsenic Beryllium
 - Cadmium Chromium Coal Smoke
 - Diesel Fumes Nickel Silica
 - Soot

Insurance: _____
Covered Benefit: Yes No
Authorization: _____
 Insurance Denied

Printed Name of Person Completing Form: _____
Signature of Person Completing Form: _____ Date: _____ Time: _____

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 unexplainable significant weight loss).

ORDER CT for Lung Cancer Screening (G0297) DX: _____
Physician Printed Name: _____
Physician Signature: _____ Date: _____ Time: _____
NPI#: _____