

TODAY'S DATE / TIME

Diagnostic Imaging Providence Lung Cancer Screening Program

Questions regarding eligibility,
call 907-212-3607
Fax order form to 907-212-5828

LUNG CANCER SCREENING WITH LOW DOSE CT (LDCT) ORDER FORM

PATIENT LEGAL NAME	DATE OF BIRTH	PATIENT PHONE
INSURANCE NAME	MEMBER / POLICY / ID #	PRE-AUTHORIZATION #
PHYSICIAN NAME	PHYSICIAN SIGNATURE	PHYSICIAN TELEPHONE
Providence Imaging Site Requested: <input type="checkbox"/> Providence Anchorage		ICD-10
Direct Physician Contact Number (pager, cell, etc.): _____ Physician Fax Number: _____ <input type="checkbox"/> Report only <input type="checkbox"/> Report and CD <input type="checkbox"/> Routine <input type="checkbox"/> Call results <input type="checkbox"/> Fax results		
Eligibility Criteria: <ul style="list-style-type: none"> • Age 50 - 80 • Asymptomatic (no signs or symptoms of lung cancer) • Tobacco smoking history of at least 20 pack-years (one pack-year = smoking one pack per day for one year; one pack = 20 cigarettes) • Current smoker or one who quit smoking within the last 15 years • Has undergone an initial counseling and shared decision making visit (elements detailed on back) <p>* If your patient is 50-54, 78-80 or has pack years <30, please ask them to confirm insurance coverage prior to completing the scan.</p>		
<input type="checkbox"/> CT Chest Cancer Screening (Baseline exam) EPIC IMG2466	<input type="checkbox"/> CT Chest Cancer Screening (Routine annual exam) EPIC IMG2466	<input type="checkbox"/> CT Chest Cancer F/U Screening (Follow-up of a finding) EPIC IMG3355
Does the patient have other comorbid conditions or poor functional status that would preclude standard therapies for lung cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the patient had a CT Chest exam within the past 12 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No
What is the actual pack – year smoking history: _____ (enter number here, i.e. 2 packs / day x 15 years = 30)		
Current smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, number of years since quitting smoking: _____		

- I believe the patient meets all Eligibility Criteria listed above that can be assessed.
- I attest the patient is asymptomatic for signs or symptoms of lung cancer.
- I attest the patient participated in initial LDCT counseling during a shared decision making visit (elements detailed on back of form).

Clinician Signature: _____ Date: _____ Time: _____

A lung cancer screening counseling and shared decision making visit includes the following elements and is appropriately documented in the patient's medical record:

- Determination of eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack – years; and if a former smoker, the number of years since quitting;
- Shared decision making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure;
- Counseling on the importance of adherence to annual lung cancer LDCT screening, impact on comorbidities and ability or willingness to undergo diagnosis and treatment;
- Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing information about tobacco cessation interventions.

Helpful resources regarding eligibility criteria for lung cancer screening and to guide shared decision making visit may be found at:

www.screenlc.com for Shared Decision Making Tool

acr.org or call Imaging Nurse 907-212-3607

Please fax the front portion of this order form to 907-212-5828.