Davis MedicalCenter
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CT Lung Screening Order Form

Patient Name:_____ DOB:_____ **(must be age 55-77)**

Height:_____ Weight_____

Packs/Day (20 cigarettes/pack)____ **X** Years Smoked____ = Pack Years_____ **(30 pack years minimum)**

Currently smoking? Y N If not smoking, how many years quit? _____ **(must be less than 15 years to qualify)**

Ordering Physician:_____ Phone:_____

National Provider Identifier (NPI):_____ Fax:_____

☐ CT Lung Screening Exam (initial, repeat or follow-up) G0297

Comments:_____
_____
_____

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. The patient will be offered the option of attending a smoking cessation class at Davis Medical Center during the scheduled appointment time
- The patient is asymptomatic (no symptoms such as fever, chest pain, new shortness of breath, now or changing cough, coughing up blood, or unexplained significant weight loss)

Ordering Physician Signature:_____ Date:____/____/_____