Brookings HEALTH SYSTEM

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Central Scheduling
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CT Lung Cancer Screening Order Form

Patient Name:_____ MRN:_____ DOB:____/____/_____ BMI_____

Packs/day (20 cigarettes/pack):_____ X Years smoked:_____ = Pack years:_____

Currently smoking? ○ Yes ○ No If not smoking, how many years quit? _____

Hx of Lung CA or lung nodule DX? Y or N

Ordering Physician (print name):_____ Phone:_____

National Provider Identifier (NPI):_____ Fax:_____

CT Lung Screening Exam ○ Initial ○ Repeat

○ Other _____

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, 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 unexplained significant weight loss).

Time:_____ Date:_____ Ordering Physician Signature:_____