Physician Referral Services - Intake Form
Telephone: 800-431-5151 / 508-856-5656 Fax: 508-334-7616

Enclosed is the Lung Screening questionnaire to be filled out prior to scheduling the appointment.

- Please fax questionnaire and pre-authorization number, if required.
- Radiology will review to make sure that all elements are met.
- If any elements are not met, Radiology will edit and respond to referring physician with comments.
- When all elements are met, and pre-authorization is verified, the Radiology scheduler will call the patient directly to set up the lung screening scan.

Thank you,

Physician Referral Services

Physician Referral Services - Intake Form
Telephone: 800-431-5151 / 508-856-5656 Fax: 508-334-7616 Today's Date:

Low Dose CT Lung Screening Request Form

Patient Name ____Date of Birth ______________________

Patient Phone Number ______________________ Pre Auth# _______________Insurance _______________

- Is the patient between 55-77 yrs old with 30 pack / year history of smoking? Y / N
- Actual pack per year smoking history__________________
  - One pack-year=smoking one pack per day for one year
- Is the patient asymptomatic (no signs of lung cancer) Y / N
- Is the patient a current smoker or is the patient a former smoker who has quit smoking within the last 15 years? Y /N
- If the patient is a former smoker, please state the number of years since quitting smoking. ___________

☐ **CT Lung Screening Please circle one: Initial Repeat Follow Up**

Comments: ____

By signing this order I confirm that:

- The patient has participated in a shared decision making session during which potential risks and benefits on 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 about 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 signs and symptoms of lung cancer).
- The shared decision making session is documented in the patient's medical record.

Ordering MD / LIP Signature______________________________ Date: _______________
Print Name: ____

****For Medicare patients, the initial LDCT lung cancer screening service to be ordered, a lung cancer screening counseling and shared decision meeting must occur and be documented in the patient's chart. Subsequent screenings can be ordered during an appropriate physician visit.**