# Low-Dose CT Lung Cancer Screening Order Form

**Patient Name:** ______________________________ **DOB:** ____/____/____

Packs/day (20 cigarettes/pack): __________ x Years smoked: ______ = Pack years*: ____

*Pack year calculator: smokingpackyears.com*

**Currently smoking?** ❑ **Yes** ❑ **No** **If not smoking, how many years quit?** ____

*Note: CMS eligibility requirement includes that patient is 55-77 years of age, smoked 30 pack years, and current smoker or quit within the last 15 years.*

**Ordering Provider** (print name): ______________________ **Phone:** ______________

**National Provider Identifier** (NPI): ______________________ Fax: ______________

❑ LDCT Lung Cancer Screening Exam (initial, repeat or follow-up)

❑ Other ______________________

Comments:

______________________________________________

______________________________________________

______________________________________________

By signing this order, you are certifying that:

- The patient has participated in a shared decision making session during which potential risk and benefits of LDCT lung cancer 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).

**Ordering Provider Signature:** ______________________________ **Date:** ___ / ___ / ___

*Adapted with permission from Lahey Hospital & Medical Center*