SAN ANTONIO
REGIONAL HOSPITAL

CT Lung Cancer Screening Order Form

Patient Name: _____ Height:_____ Weight:_____ DOB: _____/ _____/_____

Packs/ Day (20 Cigarettes/packs):_____ Years Smoked: _____ = Pack Years:_____

Currently smoking? ☐ Yes ☐ No If not smoking how many years since quitting?_____

Ordering Physician
(print name): _____ Phone:_____

National Provider
Identifier (NPI): _____ Fax:_____

CT Lung Screening Exam, Type of exam: ☐ Initial Scan ☐ Repeat Study ☐ Follow-up Scan

Is the patient a City of Hope Patient? ☐ Yes ☐ No

Date of last Low Dose Lung Cancer Screening CT:_____/ _____/_____/

Please instruct the patient to call 909.948.8166 to schedule a Low Dose Chest CT for Lung Cancer Screening. The patient must bring this order form with them when they arrive for their scan.

By signing this order, you are certifying that ***the following is true and that this has been documented in your physician medical record:***
All boxes in lower box must be checked

- ☐ Patient is asymptomatic (no signs or symptoms of lung cancer)
- ☐ The patient has a 20 -pack-year or more smoking history.
- ☐ The patient is a current smoker or has quite within the past 15 years.
- ☐ Patient is between 50-77 years old OR ☐ Patient is 78-80 years old
- ☐ The physician has documented the shared decision - making session in the patient's medical record
- ☐ 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 maintain smoking abstinence, including the offer of Medicare-covered tobacco cessation counseling service, if applicable.

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

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07-18 -2023