Low-Dose CT Lung Cancer Screening Order Form

Please Fax Completed Form to HCA Florida St. Lucie Hospital # 877.593.1197

Patient Name:________________________ Date of Birth: ___/___/___ SSN: xxx-xx-________________

Patient Phone#: (___) ____-_______ Allergies: ____

Patient Address: _____________________City: __________________ State:_____Zip: ________________

Currently Smoking: ☐ Yes ☐ No If not smoking, how many years since quitting? ___________

Any signs or symptoms of Lung Cancer? ☐ Yes ☐ No

Ordering Physician: __________________________ NPI#: ____

Physician Phone#: (___) ____-_______ Fax#: (___) ____-_______

<u>Please check one box only</u>:

☐ For Initial Screening
Please complete Demographics and Eligibility Assessment
Order: Low Dose CT of the Chest without contrast (CT Lung Screening)

☐ For Repeat Screen/ 1 Year Follow Up (No nodules on previous scan noted)
Please complete Demographics section only
Order: Low Dose CT of the Chest without contrast (CT Lung Screening)

Eligibility Assessment: Individuals must meet criteria below:

Requires "YES" to all:

- Age 50-77 (Age______) ☐ Yes ☐ No
- Currently a smoker or has quit within the past 15 years ☐ Yes ☐ No
- Has a ≥ 20 pack-year smoking history (Pack years______) ☐ Yes ☐ No

Physician Signature: __________________________________ Date: _________ Time:__________

LOW-DOSE CT LUNG CANCER
SCREENING ORDER FORM

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Patient Identification/Label