Low Dose CT Lung Cancer Screening Order Form

Please Fax Completed Form to HCA Florida Lawnwood Hospital, Centralized Scheduling at 877.600.9827

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#: (___) _____-_____

Please check one box only:

☐ 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:_____

HCA Florida
Lawnwood Hospital

LOW DOSE CT LUNG SCREENING ORDER

Patient Label/Identification