**LUNG CANCER SCREENING FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Patient Name:** | | | |  | | | | | | | | | | | | | | | | | **DOB:** | |  | | | | | | **SEX:** | | | | Male  Female | | | |
|  | | | |  | | | | | | | | | | | | | | | | |  | |  | | | | | |  | | | |  | | | |
| **SSN:** | |  | | | | | | | | | | **Medicare Beneficiary Number:** | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **MRN:** | |  | | | | | | | | | | | | | | | | **Screening Year:** | | | | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Mailing Address:** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **City:** |  | | | | | | | | | | | | | | State: | | | |  | | | | | | | | | | | | Zip: | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referring Physician:** | | | | | | |  | | | | | | | | | | | | | | | | | | **Physician NPI:** | | | | | | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Physician Address:** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **City:** |  | | | | | | | | | | | | | | State: | | | |  | | | | | | | | | | | | | Zip: | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Physician’s Phone #:** | | | | | | |  | | | | | | | | | | | | | **Physician’s Fax #:** | | | | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Person Completing Form:** | | | | | | | | |  | | | | | | | | | | | | | | | **Insurance Contract #:** | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PATIENT INFO:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Height:** | | |  | | | | | | | | **Weight:** | | |  | | | | | | | | | | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Current Smoker:** Yes No | | | | | | | | | | | | | | | | **Former Smoker, stopped smoking** | | | | | | | | | | | | | | |  | | | | | **Years ago** |
|  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | |  |
| **Smoking History: Smoked** | | | | | | | | | |  | | | **packs per day for** | | | | | | | |  | | | **Years** | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Chest CT Scan within the past year?**  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | |  | | |  | | | | | |  | | | | |  | | | | | | | | | | | | | | |
| **Prior Personal History of Lung Cancer?**  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | |  | | |  | | | | | |  | | | | |  | | | | | | | | | | | | | | |
| **Family History of Lung Cancer?** Parents Yes No Siblings  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Cardiovascular History (Please mark all that apply):*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| None Heart Attack Bypass Surgery Coronary Artery Stents Heart Failure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Other Risk Factors (Please mark all that apply):*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Exposure to Asbestos History of Pneumonia (past 5 years) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Please choose which best describes your patient:**

|  |  |
| --- | --- |
| **Grade** | **Description of Breathlessness** |
| 0. | I only get breathless with strenuous exercise |
| 1. | I get short of breath when hurrying on level ground or walking up slight hill |
| 2. | On level ground, I walk slower than people of the same age because of breathlessness or have to stop for breath when walking at my own pace. |
| 3. | I stop for breath after walking about 100 yards or after a few minutes on level ground. |
| 4. | I am too breathless to leave the house or I am breathless when dressing |

**By signing this order, you are certifying that:**

* 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 maintaining smoking abstinence, including the offer of Medicare-covered tobacco cessation counseling services, if applicable.
* The patient is asymptomatic for acute pulmonary disease (no fever, no chest pain, no new or changing cough and no change in quantity /color of sputum).
* Yes No The patient has signs or symptoms of Lung Cancer such as new shortness of breath, coughing up blood, new sputum production or significant unexplained weight loss.

If patient has a sign or symptom of Lung Cancer, a Chest CT with contrast should be ordered NOT a low-dose non-contrast lung cancer screening CT]

***Referring physicians****: To schedule your patient for a lung screening appointment please call 205-801-8750 option 3 and fax this completed form to the UAB Access Center at 205-731-6479.*

**The Kirklin Clinic of UAB Hospital**

**2000 6th Avenue South**

**Birmingham, AL 35233-0271**

|  |  |  |
| --- | --- | --- |
| **Physician/Provider Signature** | **DATE** | **TIME** |
|  |  |  |
|  |  |  |

**Posted: 5-23-16**