**LUNG CANCER SCREENING FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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:** |
|  |  |  |  |
| **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**