LOW-DOSE CT SCREENING FOR LUNG CANCER – PROVIDER REFERRAL FORM

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female

SSN: _____ Medicare Beneficiary #: _____

MRN: _____ Screening Year: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Referring Physician: _____ Physician NPI: _____

Physician Address: _____

City: _____ State: _____ Zip: _____

Physician Phone #: _____ Physician 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 (must be at least 30 pack/years)

Chest CT scan within the past year? ☐ Yes ☐ No

Prior personal history of lung cancer? ☐ Yes ☐ No

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 and of Medicare-covered tobacco cessation counseling services, if applicable.
- The patient is asymptomatic for acute pulmonary disease (no fever, no chest pain, or 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. Patients with lung cancer signs or symptoms should receive a chest CT with contrast (not a low-dose non-contrast lung cancer screening CT).

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

PHYSICIAN/PROVIDER SIGNATURE	DATE	TIME