

Low Dose CT Lung Screening Questionnaire Form

Early detection can save lives!

Candidates should not have a diagnosis of lung cancer within the past 5 years.

Name: _____ DOB: _____
Phone #: _____ Insurance: _____
Primary Care Physician: _____

Smoking Status: Current Smoker _____ #packs a day Current Smoker _____ years
Former/quit _____ years ago Year Quit _____
Smoking Cessation Education Given? Yes No

Category 1 Eligibility

- | | | |
|--|------------------------------|-----------------------------|
| 1. Age 55-77 Years | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Currently a smoker or have quit within 15 years | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Have smoked at least a pack of cigarettes a day for 30+ years | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

If all answers are yes, patient is eligible

Category 2 Eligibility

- | | | |
|--|------------------------------|-----------------------------|
| 1. Age 50-77 Years | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Have smoked at least a pack of cigarettes a day for 20+ years | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Have one additional lung cancer risk factor, not to include
Second hand smoke. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

If all answers are yes, patient is eligible

High Risk Factors *please check all that apply*

Family History of Lung Cancer:

- A Mother Father Sibling Child

Personal History Of Chronic Lung Disease:

B List: _____

Personal Cancer History:

C List: _____

Questionnaire may be submitted online, email to Elizabeth Slatten, RN, Lung Cancer Nurse Navigator at eslatten@crmhealth.org. Please contact Beth at 931-783-4996 for questions or clarification.

FOR OFFICE USE ONLY - DO NOT FILL OUT

Eligible: Yes No Approved by: _____ Date: _____
Date Scheduled: _____