

Low Dose CT Lung Screening Questionnaire & Order 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 55-74 Years YES NO
 2. Currently a smoker or have quit within 15 years YES NO
 3. Have smoked at least a pack of cigarettes a day for 30+ years YES NO
If all answers are yes, patient is eligible

Category 2 Eligibility

1. Age 50-74 Years YES NO
 2. Have smoked at least a pack of cigarettes a day for 20+ years YES NO
 3. Have one additional lung cancer risk factor, not to include Second hand smoke. YES 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@crmchealth.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: _____

Order for CT Lung Screening:

Ordering Physician: _____
 Date: _____
 Other Pertinent History/diagnosis _____
 Please fax to nurse navigator at 931-783-5868