The IMAGING CENTER at COOKEVILLE REGIONAL
It's the Way WeCARE

Low Dose CT Lung Screening Questionnaire & Order Form

To schedule call Imaging at (931)783-2222,
fax order and screening questionnaire to (931)783-2688

Patient Name: _____ Age: _____

DOB: _____ PHONE #: _____

Packs/day (20 cigarettes/pack): _____ x Years smoked: _____ = Packs years*: _____

Currently smoking? ❑ Y ❑ N If not smoking, how many years quit? _____

Smoking Cessation Education Given? ❑ Y ❑ N

Ordering MD (print name): _____ Phone: _____

*National Provider Identifier (NPI): _____ Fax: _____

❑ **Perform Low Dose CT Lung Cancer Screening (initial, repeat or follow-up)**

Comments: _____

_____

Category 1 Eligibility - ***If all answers are yes, patient is eligible***	**YES**	**NO**
Age 55-77 Years		
Currently a smoker or have quit		
Have smoked at least a pack of cigarettes a day for 30+ years		

Category 2 Eligibility - ***If all answers are yes, patient is eligible***	**YES**	**NO**
Age 50-77 Years		
Have smoked at least a pack of cigarettes a day for 20+ years		
Have on additional lung cancer risk factor, not to include second hand smoke		

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: _____

By signing this order, you are certifying that:

- The patient is asymptomatic (no symptoms such as fever, chest pain, new shortness of breath, new or changing cough, coughing up blood, or unexplained significant weight loss).
- 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 important 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.

Ordering MD Signature: _____ **Date:** _____ **Time:** _____

I hereby authorize Cookeville Regional Medical Center to perform a Low-Dose Computed Tomography Scan of the chest to evaluate for Pulmonary Nodules, which may reflect early lung cancer. This offers the best chance of finding lung cancer in its earliest and most curable stages.