

Covenant Cancer Care Center
Lung Cancer Screening Program

LOW-DOSE COMPUTERIZED TOMOGRAPHY (LDCT) PRESCRIPTION

Patient: Name _____ Date _____

Date of birth _____ Height _____ Weight _____ MR# _____

Clinical Decision: ID _____ Score _____

Vendor _____ Adherence _____

REQUIRED: Clinical Decision criteria must be completed to schedule an appointment.

- Please select one: **LDCT Lung Cancer Screening Annual**
 LDCT Lung Cancer Screening Baseline
 LDCT Lung Cancer Screening Follow-Up (physician visit not required)

Screening Criteria

NOTE: The following people DO NOT QUALIFY for LDCT: CT chest in the past year, Harrington rod, pacemaker, home oxygen or history of lung cancer in the past five years.

Patient must meet ALL criteria listed below:

- Yes No Age 55-77
- Yes No Currently smokes cigarettes
- Yes No Quit smoking within the last 15 years • If yes, year of quit date _____
- Yes No Smoked 30 pack years or more • If yes, how many packs a day _____ for how many years _____
- Yes No Had a CT chest within the last year
- Yes No Has shown signs or symptoms of lung cancer
- Yes No Is oxygen dependent
- Yes No Has defibrillator or pacemaker
- Yes No Has metal implant in spine (Harrington stabilization rod)
- Yes No Has known coronary artery disease
- Yes No Completed *Shared Decision Making/Counseling Appointment* • Date _____
- Yes No N/A Completed *Smoking Cessation Counseling*

By signing this order, I am certifying that the patient has participated in a *Shared Decision Making/Counseling Appointment* regarding the lung cancer screening AND has received *Smoking Cessation Counseling* (if indicated).

Referring provider: Signature _____

Phone # _____ Authorization # _____

To Schedule a LDCT Lung Cancer Screening

- Fax this completed prescription to 989.583.7029.
- Schedule the appointment by calling 989.583.6279.

If you have questions, please contact the Covenant Cancer Care Center at 989.583.5014.

