Lung Cancer Screening Program

Stamford Hospital/Department of Radiology

Scheduling Telephone: 203.276.2602 Fax: 203.276.4590

Patient Name: _____

DOB: _____ Male ☐ Female ☐

Address: _____

Phone Number: _____

☐ **Low Dose CT Scan Chest** **Diagnosis: High-risk patient**

☐ **F/U Low Dose CT Scan Chest** **Diagnosis: Lung Nodule(s)**

(Use this if a 3 month or 6 month CT is recommended — LungRADS 3 or 4A on Lung Screening)

Pack/Day: _____ x Years Smoked: _____ = Pack Years: _____

(20 cigarettes per pack)

Is patient an active smoker? ☐ Yes *(Offered smoking cessation program)*
203.276.QUIT (7848) — Commit to Quit at Stamford Hospital

☐ No If not smoking, years since quitting: _____

High-Risk Criteria

Patients must meet all of the following criteria to be eligible for a screening chest CT:

- Age 50-80
- Current cigarette smokers or those having quit within the past 15 years
- 20+ pack year history of smoking
- Asymptomatic *(no active signs/symptoms of lung cancer)*

By signing this order, you are certifying that:

☑ The patient has participated in a shared decision making session regarding the benefits and risks of Lung Cancer Screening. Risks discussed included false-positives, over diagnosis, radiation exposure, and anxiety. *(Required for initial lung screen only.)*

☑ 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.

☑ 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).*

Physician's Signature: _____ Date: _____

Print Physician's Name: _____ NPI: _____

***Note: All information must be completed prior to a scheduled exam.**

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