Baptist Health

LOW DOSE CT LUNG CANCER SCREENING PHYSICIAN ORDERS

LOW DOSE CT LUNG CANCER SCREENING PATIENTS MUST MEET ALL OF THE FOLLOWING CRITERIA.
Please check or answer all of the questions below. Once completed, please fax this form to one of the following numbers before the patient's appointment date. Thank you.

FAX NUMBERS:

Baptist Health Imaging Center-Kanis	501-202-4025
Baptist Health Imaging Center-NLR	501-202-6985
Baptist Health Imaging Center-Benton	501-776-2153 *(No Medicare at Benton center)*
Baptist Health Imaging Center-Fort Smith	479-709-6817
Baptist Health Medical Center-Conway	501-585-2906

Patient Name: _____

DOB: _____

Diagnosis Code: _____

To qualify, patients must meet **ALL** of the following criteria. Please indicate response in the blank spaces:

_____ Is the patient between the ages of **55-77** (Medicare) or **55-80** (all other insurance)?

_____ Does the patient have a smoking history of AT LEAST 30 PACK YEARS?
(Pack Years = Number of packs per day X number of years smoking)
_____ Number packs per day
_____ Number of years smoking

_____ Patient shows **NO** signs or symptoms of lung cancer.

_____ Is the patient a *Current Smoker* or *Former smoker* who has quit **WITHIN** the last **15** years?
_____If former smoker, how many years since quitting?

_____ Is this the first (baseline) CT lung screen or a yearly (annual) Exam?

_____ Has the patient received smoking cessation counseling or materials from ordering physician?

Referring Physician: _____

Referring Physician signature: _____ Date: _____

Insurance Authorization number: _____

Patient Signature: _____ Date: _____

OFFICE USE ONLY:

CTDI _____ DLP: _____