

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 55-77
- Current cigarette smokers or those having quit within the past 15 years
- 30+ 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.**

