VANCOUVER RADIOLOGISTS

VANCOUVER RADIOLOGISTS
Scheduling: 360.254.4914
Fax: 360.449.4987

Vancouver Village Shopping Center
4816A NE Thurston Way
Vancouver, WA 98662

South View Center at Fisher's Landing
3250 SE 164th Ave., Ste. 108
Vancouver, WA 98683

APPOINTMENT:
DATE ____________
TIME ____________
LOCATION ____________

Patient Information

Order Date ____________
Name ____________
Phone ____________ **DOB** ____________
Height ____________ **Weight** ____________

Referring Provider Information

Name ____________
Organization ____________
Office Phone # ____________ Fax # ____________
After Hours Phone ____________ CC Other Treating MD ____________

Insurance Information

Insurance ____________
Authorization # ____________

When the Exam is Completed

- ○ Urgent Preliminary Report (STAT)
- ○ Hold Patient
- ○ Phone consult with Radiologist
- ○ Burn CD ____________

Please notify us if relevant comparison films, reports or current labs are available.

LUNG CANCER SCREENING WITH LOW DOSE CT (LDCT) ORDER FORM

Eligibility Criteria:

* Age 55 - 77
* Asymptomatic (no signs or symptoms of lung cancer)
* Tobacco smoking history of at **least** 30 pack-years (one pack-year = smoking one pack per day for one year)
* Current smoker or one who quit smoking within the last 15 years
* Has undergone an **initial** counseling and shared decision-making visit

☐ CT Chest Lung Screening Exam

Smoking history: (Required)

Packs/day (20 cigarettes/pack): ____________ x Years Smoked: ____________ = Pack Years: ____________

Currently smoking? ○ Yes ○ No If no, number of years since quitting smoking? ____________

Has the patient ever had lung cancer? ○ Yes ○ No Any other cancer? ____________

By signing this order, you are certifying that:

* The patient has participated in a shared decision-making session which potential risks and benefits of CT lung screening were discussed.
* 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, including the offering of Medicare-covered tobacco cessation counseling services, if applicable.
* 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).

Ordering MD Signature: ____________ **Date:** ____ /____ /________