**Lung Cancer Screening CT Eligibility Form**

Include this form with your Lung Cancer Screening CT order if you are not ordering through Boston Medical Center’s Epic Electronic Medical Record System

Fax this form and Lung Cancer Screening CT order to: 617-414-7891

AND Call: 617-414-9729

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| **Patient Name** |  |
| **Patient Age and Date of Birth**  (must be age 55-77 for Medicare;  age 55-80 for private insurance) | Age: \_\_\_\_\_\_  Date of Birth (MM/DD/YYYY): \_\_\_/\_\_\_/\_\_\_\_\_ |
| **Patient Phone Number** | Phone: |
| **Smoking status** | ∏ Current smoker ∏ Former smoker |
| If former smoker, years since quitting  (must be < 15 years) | Years since quitting smoking: \_\_\_\_\_\_\_ |
| **Pack years:**  Number of pack-years (packs per day  times number of years smoking)  (must be > 30) | Pack years of smoking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Asymptomatic: no signs/symptoms of lung cancer** (ex: weight loss, hemoptysis)  (must be YES)  (if NO, order a diagnostic CT scan instead) | ∏ Yes (asymptomatic) ∏ No (symptoms) |
| **A shared decision making visit was conducted and documented**  (must be YES) | ∏ Yes ∏ No |
| **Tobacco cessation/abstinence counseling was provided**  (must be YES) | ∏ Yes ∏ No |
| **History of prior cancer (any type)** | ∏ Yes ∏ No |
| If yes (prior history of cancer), what  type of cancer | Type of prior cancer: |