LOW DOSE CT (LDCT) LUNG CANCER SCREENING PROGRAM

PHYSICIAN REFERRAL/ORDER FORM

Please fax completed form to 410.414.9118

CalvertHealth Cancer Center

DukeHealth AFFILIATE

Patients who have a primary care provider can self-refer to the program if they meet the inclusion criteria (outlined below). Please have them call the Lung Screening Program at **410.414.4575**, a referral form is not needed. Otherwise, please complete this form for any patients who you consider may experience barriers to self-referral (e.g. language barrier, screening hesitancy).

If you would like more copies of this referral form, please visit BC Cancer's Health Professionals page at: https://www.calverthealthmedicine.org/Lung

Patient Name: _____ Date of Birth: ____/____/_____

Current Height: _____ Current Weight: _____

Daytime Phone: _____ Cell Phone: _____

Referring Physician: _____ NPI # _____

Contact Name: _____ (P)_____ (F)_____

ELIGIBILITY (all must be completed)

Patient's Current Age: _____

Avg. packs per day _____ x # yrs. smoked _____ = _____ pack-years

Smoking Status: ❑ Current Smoker

❑ Former Smoker If Former, # years since quit ____

Current Symptoms of Lung Cancer? ❑ Yes ❑ No

CMS Criteria (Must meet all 4):

· Age 55-77

· ≥ 20 pack-years

· Current Smoker or Quit within last 15 years

· No lung cancer symptoms

Criteria for other Insurers may differ. Patients not meeting criteria may be responsible for payment.

PREVIOUS CHEST CT?

Previous Chest CT date (mm/dd/yyyy): _____

Previous Chest CT location: _____

Thank you for referring your patient to the High-Risk Thoracic clinic. Patients will be contacted by our Nurse Navigator to confirm lung screening eligibility.

Provider Signature:	Date:

For further assistance, please contact **CalvertHealth's High-Risk Thoracic Clinic** at **410.414.4575**