

**CT LUNG CANCER
SCREENING REQUEST FORM**

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- UMass Memorial Medical Center
- UMass Memorial HealthAlliance-Clinton Hospital
- UMass Memorial Health - Harrington Hospital
- UMass Memorial - Marlborough Hospital
- UMass Memorial Medical Group - Location: _____

NAME: _____

BIRTHDATE/AGE: _____

SEX: _____

MEDICAL RECORD NUMBER: _____

HAR / CSN ACCOUNT NUMBER: _____

PRINT CLEARLY IN INK OR APPLY PATIENT LABEL

ALL INFORMATION IS REQUIRED

*Please contact the CT lung cancer screening office if you have any questions:

Phone: 774-441-8444 Email: CTLungCancerScreening@umassmemorial.org

PATIENT NAME: _____	
DOB/AGE (must be between 50-80 years): _____ / _____ yrs	
ADDRESS: _____	
PHONE: _____	
IS INSURANCE AUTHORIZATION REQUIRED?	
<input type="checkbox"/> YES PA NUMBER _____ DATE START: _____ DATE EXP: _____	
<input type="checkbox"/> NO AUTHORIZATION NEEDED (Medicare covers patients 50-77)	

*Please fax this request form, a recent clinic note, and insurance authorization documentation, to the lung cancer screening office: 774-441-8431

*Please note that any non-screening CT chest exam will push out a baseline and 12-month follow-up CT lung cancer screening for 366 days

1. Is the patient pregnant? Yes No
2. What is your preferred location for CT exam?
 UNV MEM HA LC HAR MARL CLINTON NO PREFERENCE
3. Is the patient either a current cigarette smoker or a former cigarette smoker who has quit cigarette smoking less than 15 years ago? Yes No
 If the patient is a former smoker, please state the number of years since quitting smoking cigarettes _____
 (if quit 15 years or greater, patient is ineligible for LCS program. Only cigarette smokers are eligible. Pipe, cigar, vaping, are excluded)
4. Actual pack per year cigarette smoking history: _____ PY (ineligible if less than 20 PY)
 (one pack per day x one year = 1 PY, 2 packs per day x 10 years = 20PY)
 Did the patient participate in shared decision making during which the benefits and harms of screening, follow-up testing, over-diagnosis, false positive rate and total radiation exposure were discussed? Yes No
5. Does the patient show any signs or symptoms of lung cancer or does the patient have a history of other cancer?
 (Ex. dyspnea, cough without clear etiology, hemoptysis, loss of appetite, unexplained/unintentional weight loss. Patients must be cancer free of ALL cancers - excluding basal cell skin cancer, for the past five years.) Yes No
6. Does the patient have any prior Chest CT studies performed outside of UMMHC? Yes No
 If yes, where: _____
7. Is this the first (baseline) lung cancer screening CT or a follow-up CT lung cancer screening?
 Baseline LCS 3-month f/u LCS 6-month f/u LCS 12-month f/u LCS
8. **With your patient now enrolled in our CT lung screening program, we would be happy to place future orders for CT LCS follow-up examinations, along the management recommendations of our program. Please let us know if you agree or disagree:** I agree I do not agree

By signing this order, I confirm that shared decision-making was done using one of the decision aids (resources on page 2):

 Provider signature Printed name Date Time

Tel: _____ Fax: _____ NPI: _____



Resources for Shared Decision-Making Counseling:

VA Lung Cancer Screening Website
<https://lungdecisionprecision.com>

Patient Decision Aid and Provider Resources for Lung Cancer Screening from the Agency for Healthcare Research and Quality (AHRQ)
<https://effectivehealthcare.ahrq.gov/decisio-aids/lung-cancer-screening/home.html>

Example of Shared Decision-Making Counseling Documentation:

I have used a decision aid to share decision-making with the patient about interventions to reduce the risk of dying from lung cancer, including: quitting smoking/staying smoke free and annual lung cancer screening. The patient is eligible for screening based on age, smoking history, and the absence of signs or symptoms of lung cancer. We discussed the potential harms of screening, including false positives, follow-up diagnostic testing, overtreatment, and total radiation exposure. We provided the patient information about the importance of adherence to annual low dose CT screening, the impact of comorbidities, and the ability/willingness to undergo diagnosis and treatment.

Patient Age _____

Current smoker: _____ pack years smoking history

Former smoker: _____ years since quit

After considering the patient's unique circumstances and the pros and cons of the alternatives, the patient has decided to:

be screened

NOT be screened

