

Out-patients Radiology & Diagnostic Imaging CT Lung Cancer Pre-Screening Questions

Today's Date: _____

Patient Name: _____

Ordering Provider: _____

Patient DOB: _____

Requested Procedure: _____

Phone: _____

****Please specify if you want the patient entered into the Providence Medical Group Lung Cancer Screening Program for us to follow your patients and order the Low Dose CT scan.****
(See page 3 for instructions)

**** If you are following your patient and would like to order Low Dose CT scan-Please complete the following CT Lung Cancer pre-screening questions, attach your "Shared Decision-Making Visit" chart note and return for us to be able to process the order and information in our system prior to getting the patient scheduled ****

1. Reason for Exam: _____
2. Is the patient between the ages of 50 and 77, a current or former smoker (quit within last 15 years) and have a 30+ pack year smoking history? ____ NO ____ YES

- a. If answer is NO: ***ADVISORY*** This patient does not meet criteria for Lung Cancer Screening. Please choose an appropriate exam or consult with a radiologist before placing this order.
- b. Please see the Lung Cancer Screening Insurance Criteria below prior to completing this form:

Reference Site	Criteria	Insurance
Gotofoundation.com Guidelines	Age Range: 55-80 Pack Year History: 30	Cigna Humana Aetna
CMS Guidelines	Age Range: 55-77 Pack Year History: 30	Medicare Medicaid Regence
American Cancer Society Guidelines	Age Range: 50-80 Pack Year History	Tricare Lifewise Premiera Kaiser UHC
Shouldiscreen.com Guidelines	Age Range: 50-80 Pack Year History: 20	Tricare Lifewise Premiera Kaiser UHC
i. Unable to find coverage criteria on website		Ambetter Coordinated Care

3. Does the patient show any signs or symptoms of lung cancer? ____ NO ____ YES

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- a. **If NO** – Is this the first (baseline) CT or an annual exam?
i. ☐ Baseline ☐ Annual
- b. **If YES** – Order would need to be a CT Chest w/o.
- c. **If YES** - *ADVISORY* This patient does not meet criteria for Lung Cancer Screening. Please choose an appropriate exam or consult with a radiologist before placing this order.

4. **What is the patients smoking status?**

- a. ☐ Current Smoker
- b. ☐ Former Smoker
i. ☐ Years Since quit (value cannot be zero)
- c. ☐ Never Smoker
- d. ☐ Smoker current status unknown
- e. ☐ Unknown if ever smoked

5. **Patients smoking history: Pack Years (packs per day x years smoked):** _____

6. **Is there a documentation of shared decision making?** ☐ NO ☐ YES

- a. **IF NO** – The PCP Needs to complete the screening and follow the patient or the patient can be referred to either Swedish or The Everett Clinic to enroll in their LDCT Screening program.
- b. **IF YES** – Ordering MD will be following their patient:

i. **PLEASE INCLUDE THE FOLLOWING WITH THE ORDER:**

1. Order
2. Authorization
3. Documented Chart Note
4. This Completed Form – CT Lung Cancer Pre-Screening Questionnaire

7. **Was the patient informed of the importance of smoking cessation and/or maintaining smoking abstinence?** ☐ NO ☐ YES

8. **What is the preferred imaging location?** ☐ Providence Colby Campus
☐ Providence Monroe