TORRANCE MEMORIAL
HUNT CANCER INSTITUTE

CT LUNG SCREENING ORDER FORM

1. To schedule call 310-517-4738
2. Fax completed order form to Thoracic Nurse Navigator at 310-784-8722

****ALL this information must be completed prior to scheduling**

Patient Name: _____ **DOB:** ___/___/____ **Patient Phone #:** _____

Eligibility Criteria:

Age: ____ Patient must be 55-77 for Medicare reimbursement OR 55-80 for most private insurance
***Torrance Memorial Cash Price $205.00**

Packs/day (20 cigarettes/pack): _____ x Years smoked: _____ = **Pack years***: _____
***Must have ≥30 pack year history for medicare reimbursement**

Current smoker: No Yes **Former Smoker:** # of years since quitting _____
***This number must be ≤15 years for medicare reimbursement**

Personal or Family History of cancer: No Yes If Yes specify: _____

History of COPD: No Yes **History of Emphysema:** No Yes **Height**: _____ **Weight**: _____

- Screening Exams are done at Torrance Memorial Polak Imaging Pavilion, 3275 Skypark Drive, Torrance, CA 90505
- Please instruct patient to call the Thoracic Nurse Navigator at 310-517-1072 to schedule smoking cessation class

By signing this order, you are certifying that:

- The patient has participated in a shared decision making session during 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 offer 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).
- Referred to Thoracic Nurse Navigator for smoking cessation counseling

Ordering MD (print name): _____ Phone: _____

National Provider Identifier (NPI): _____ Fax: _____

Ordering MD signature: _____ Date: _____

Commission on Cancer® ACCREDITED PROGRAM

American Cancer Society

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AMERICAN LUNG ASSOCIATION IN CALIFORNIA