



Cancer Prevention & Navigation Services

Risk Modification Questionnaire/Order for Lung Cancer Screening (Low-Dose CT Scan)

Print your name: _____ Date of Birth: ___/___/___ Zip Code: _____

Phone # (1): _____ Phone # (2): _____ Your age (must be ≥50): _____

_____ I am aware this screening cost \$185 and is not covered by insurance.

How did you hear about us? TV___ Mailing___ Radio___ PCP___ Newspaper___ Friend___ Relative___

(We ask for race and ethnicity so we can focus on improving the quality of care for our many diverse communities and cultures in the Kentuckiana area.)

_____ Race (C-Caucasian, AA-African-American, A-Asian, U-Unknown)

_____ Ethnicity (HL – Hispanic/Latino, NHL – Non Hispanic/Latino, U - Unknown)

Have you had a CT of the chest in the last 24 months? Yes___ No___

Do you currently have lung cancer? Yes___ No___

Smoking History: Current smoker?_____ Past smoker?_____ (how many years since you quit?_____)

How many packs do / did you smoke in a day?_____ How many years have / did you smoke(d)? _____

What is your "Pack-Year"* total? _____ (It must be at least 30 for you to qualify) *Your Pack-Year is determined by multiplying the number of packs per day by the number of years smoked. For example: if you smoked 1 1/2 packs a day for 20 years, you multiply 1 1/2 X 20 which will be a 30 Pack-Year)

If your Pack-Year is at least 20, you may still qualify if you answer "Yes" to any of the 4 statements below:

- 1. Do you have a personal history of cancer? Yes___ No___
2. Family history of lung cancer? Yes___ No___
3. COPD or pulmonary fibrosis? Yes___ No___
4. Worked in an environment or extended exposure to radon, silica, cadmium, asbestos, arsenic, beryllium, chromium, diesel fumes or nickel? Yes___ No___ Where and when: _____

-----DO NOT DETACH-----

Physician Order - Low Dose CT for Lung Cancer Screening

Who is your Primary Care Physician? _____ Office Phone? _____

We need to obtain your physician's signature before we can schedule your lung screening. Please have him/her sign below and fax it to us at 502-210-4475, or call us at 1-855-345-9663 for more help. Once we receive the signed order we can schedule your procedure.

Physician Signature: _____ Date: ___/___/___

(Office use only) Facility: _____ Appt Date: ___/___/___ Appt Time: _____