

## Jewish Cancer Prevention and Navigation Services Risk Modification Questionnaire/Order

Name:	Date of Call:	
Phone	#: DOB: Age (must be ≥50): Zip	Code:
	I am aware this screening cost \$185 and is not covered by insurance	
1.	on Criteria:  Have you had a CT of the chest in the last 24 months? Yes No  Do you currently have lung cancer? Yes or No	
Smokin	g History:	
1.	Current smoker Never smoked Former smoker (years without	smoking)
2.	How many packs did you or do you smoke a day?	
3.	How many years have you smoked/did you smoke?	
Pack-ye	ear total*: (30 pk/ yr meets criteria. If $20 - 29.9$ pk/ yr, patient must meet one (*Pack-year is determined by multiplying the number of packs per day by the number	
Additio	nal risk factors for 20 pack year:	
2. 3.	Do you have a personal history of cancer? Yes No  Family history of lung cancer? Yes No  COPD or pulmonary fibrosis? Yes No  Worked in an environment or extended exposure to radon, silica, cadmium, asbestos, chromium, diesel fumes or nickel? Yes No Explain	
based u	c assessment contains information obtained directly from the patient. For patients who ipon the risk assessment, this form will be faxed to the patient's PCP for his/her orderion not have a PCP may be assigned a JPG PCP based upon patient preference, and/or ziped through Allscripts, the risk assessment will be obtained before scheduling to ensure of the content of the patient.	ng signature. Patients code. For referrals
	Physician Order - Low Dose CT for Lung Cancer Screening	
Date: _	// Physician Name: Office Pho	one:
Lexingt	on Locations:BRI -BOLBRI -EBRI -W	
Louisvi	lle Locations:JHMCEJHMNEJHMCSJHMCSWJH Shelbyville	
Appt. D	oate:/ Appt. Time: (Arrive 15 minutes prior to appo	ointment time)
Physicia	an Signature: Dat	e:/

Please fax this signed /dated order to Cancer Prevention and Navigation Services.

FAX 502-210-4475.

Upon receipt of the signed / dated order, our Navigator will schedule this exam.