

CLINICIAN ORDER: LOW-DOSE CT SCAN LUNG CANCER SCREENING PROGRAM Program Coordinator (617) 667-5712

| | (***) 501 57 12 | | | | |
|--|--|----------------------|--|--|----------------|
| ☐ Enrollment / Initia | al Scan 🔲 Repeat | t / Follow- | up Scan | | |
| Your patient will be and coordinate all fu | contacted by the Pro orther imaging and fol | gram Coo llow-up. | ordinator who will dis | cuss the program in | detail |
| Patient Demograp | hic Information | | | | |
| Patient Name: | | | | | |
| MRN: | | Date of | Birth:// | | |
| Address: | | | | | |
| | | | | | |
| Contact Number: | | | | ☐ Home ☐ Cell | Work |
| Insurance Referral | Authorization (if requi | red): | | | |
| Patient Clinical Inf | ormation | | | | |
| Current Smoker: | ☐ Yes ☐ No | If No, how | w many years quit - | | |
| Packs/day (| 20 cigarettes/pack) | x | Years smoked = | Pack years | |
| Asymptomatic: | ☐ Yes ☐ No | | | | |
| Comorbidities or Pa | st Cancers: Yes | □No | If Yes, specify - | | |
| | | 400 | | | |
| Smoking Cessation Education Offered: | | | | | |
| Ordered by: | | | | | |
| X | | | | | |
| Clinician Signature & Credential Print Name | | | Print Name | // | Time (24 hour) |
| Contact Numl | oer: | | | | |
| National Prov | ider Number (NPI): | | | | |
| Prohibited Abbreviation MS or MSO ₄ MgSO ₄ Trailing Zeros (e.g. 5.0) Leading Zeros (e.g5) U (for Unit) | Preferred Term Write Morphine Sulfate Write Magnesium Sulfate Write 5 Do not use zero after Write 0.5 Use a zero before a Write Unit | decimal decimal | Prohibited Abbreviation ug QD or q.d. QOD d TIW or tiw | Preferred Term Write mcg or Microgram Write Daily or Once Daily Write Every Other Day Write Days or Doses Specify which three days | |

FAX THIS ORDER TO: (617) 667-5715.

Write Unit or International Unit

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Specify which three days of the week