Early Detection of Lung Cancer Examination

Low Dose Chest CT

Patient Eligibility Requirements:

☐ Age 55-77
☐ > 30 Pack-Year Smoking History

Does your patient wish to participate in a smoking cessation program?
Yes ☐ No ☐

Prior CT chest: Yes ☐ No ☐ If Yes: date, location of last chest CT: ________________

1) Current smoker
   YES ☐ NO ☐ If No, indicate date quit: ________________

2) Repeated exposure to second hand smoke
   YES ☐ NO ☐

3) Exposure to asbestos
   YES ☐ NO ☐

4) History of tuberculosis
   YES ☐ NO ☐

5) Previous diagnosed lung disease
   YES ☐ NO ☐ If Yes, indicate ________________
   (Eg. asthma, emphysema, bronchitis, recurrent pneumonia)

6) Cough / wheezing / shortness of breath
   YES ☐ NO ☐

7) Coughing blood
   YES ☐ NO ☐

8) Unexplained weight loss
   YES ☐ NO ☐

9) Family history of lung cancer
   YES ☐ NO ☐

Incomplete Requisitions will be returned for completion

Physician Name (Print) ____________________________ Telephone ____________________________
Physician Signature ____________________________ Date ____________________________

Please fax all requisitions to Corporate Navigator. Appointment will be given by telephone or mail notification.