

Memorial Hermann Outpatient Imaging Centers

PHYSICIAN ORDER FORM: Low Dose CT (LDCT) Screening Exam- for Lung Cancer

LDCT Screening Exams are available throughout the Greater Houston area:

Greater Heights · The Woodlands · Texas Medical Center · Memorial City · Northeast · Southwest · Southeast
Sugar Land · Pearland · Katy · Katy Rehabilitation

Please use the following contact numbers to submit this order form and schedule an appointment:

Greater Heights:
Phone: 713-867-3336
Fax: 713-867-4630

Southeast:
Phone: 281-929-6485
Fax: 281-929-4710

All Other Locations:
Phone: 877-704-8700
Fax: 713-512-6041

Patient Assessment

According to the U.S. Preventive Services Task Force (USPSTF), a LDCT lung screening is recommended for people who are at high risk of lung cancer. Patients who are, or may be, at high risk fit the following criteria:

- Aged 50-80 **AND**
- Currently, or in the past, have a 20 pack-year smoking history for 15 years **AND**
- A current smoker or one who has quit within the last 15 years **AND**
- Has no signs or symptoms of lung cancer.

Shared Decision Making

- The patient has participated in a shared decision making session during which potential risk and benefits of CT lung screening were discussed.
- The patient was informed of the importance of adherence to annual screening, impact of co morbidities, and ability/willingness to undergo diagnosis and treatment.
- The patient was informed of the importance of smoking cessation and/or maintaining smoking abstinence.

Required Data Items on the LDCT order:

1. Patient Name _____ DOB _____
2. Packs/day: _____ x Years smoked _____ = Pack years _____
3. Currently smoking? Y N ** for former smokers, how many years since quitting? _____

MD ORDER

- Initial Low Dose Chest CT lung scan without Contrast
- Less than 1 year follow-up Low Dose Chest CT lung scan without Contrast due to lung nodules
(last screening date _____)
- 1 year follow-up Low Dose Chest CT lung scan without Contrast
(last screening date _____)
- 2+ year follow-up Low Dose Chest CT lung scan without Contrast
(last screening date _____)
- Nurse Navigator to provide patient with information on Tobacco Cessation and related program(s).

When radiology report is completed, fax results to: _____

Reason for exam _____

Signature _____ Physician Print Name _____ NPI/MHHS ID. _____ Date _____ Time _____ Contact No. _____

AM
 PM

**MEMORIAL
HERMANN**
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