SALEM HEALTH
An OHSU Partner

Lung Cancer Screening
LDCT Eligibility and Referral

Please **fax** completed form to Salem Cancer Institute at **503-814-1448.**

Provider Contact Information

Ordering Provier:_____________________________________NPI:__________________________

Clinic:____

Phone:____Fax: ___________________________

Insurance:____Auth #: ________________________

Eligibility Criteria – *must be completed by provider*

Packs/day (20 cigarettes/pack)________x Years Smoked___________ = Pack Years_________(must be minimum of 30)
Pack-year Calculator: http://smokingpackyears.com

☐ Active Smoker ☐ Quit - # of years since quit **(must be 15 years or less to qualify)** _________

By signing this order, you are acknowledging the following eligibility for your patient:

- Asymptomatic **(no symptoms of lung cancer)**
- Between the ages of 55 and 80
  (Medicare/Medicare Managed Care patients age 78-80 are eligible for screening as self-pay)
- The patient has participated in a Shared Decision Making session for their initial screening.
- The patient was informed of the importance of smoking cessation and/or maintain smoking abstinence, and if appropriate, furnishing of information about tobacco cessation interventions.

Imaging Order

Last Name:____________________________First Name: ________________________________

Phone:_______________________________DOB:_______________________________________

Exam: ☐ G0297 Low-Dose Chest CT-Lung Cancer Screening

Dx: ☐ Z87.891 Former Smoker
☐ F17.210 Current Smoker
☐________________________

Physician Signature:_______________________________________ Date:______________________

Please include the most recent chart notes

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For questions, please call 503-814-1458.

Last Revised
11/2016