



AUBURN
COMMUNITY
HOSPITAL

We Specialize in You

CT LUNG SCREENING FORM

(Needed for Initial Scan Only)

Patient Name: _____ MRN: _____

DOB: _____ Exam Date: _____

Lung Screening Inclusion Criteria

Must meet all 3 criteria to qualify for lung screening.

1. Do you currently smoke? No Yes

If No, when did you quit? _____

(If quit 15+ yrs - does not qualify)

2. SMOKING HISTORY: PACKS/DAY x YEARS = PACK YEARS

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TOTAL PACK YEARS: _____

(20+ pack years smoking history required for screening)

3. Age: _____ (Must be 50-80 for insurances to cover)

Additional History

1. Have you had a chest CT before? No Yes

If Yes, where & when: _____

2. Have you been diagnosed with Cancer? No Yes

If Yes, what kind: _____

3. Have you had surgery of the chest? No Yes

If Yes, what kind & when: _____

Screening obtained from: Patient Chart Physician Family

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____