



## CT LUNG SCREENING

See reverse for Appointment Scheduling

Patient Name \_\_\_\_\_

Appointment Date and Time \_\_\_\_\_

Email Address \_\_\_\_\_

( ) -  
Phone \_\_\_\_\_

/ /  
Date of Birth \_\_\_\_\_

☐ St. Paul

☐ Coon Rapids

☐ Northwest (Coon Rapids)

Age \_\_\_\_\_ (Must be 50-80)  
(Medicare 50-77)

☐ Burnsville

☐ Maple Grove

☐ Southdale (Edina)

### Lung Screening Information

Packs Smoked Each Day (20 Cigarettes Per Pack): \_\_\_\_\_ x Years Smoked: \_\_\_\_\_ = Pack Years\*: \_\_\_\_\_

\*Online pack year calculator: [www.smokingpackyears.com](http://www.smokingpackyears.com) (Must be at least 20 pack years)

Currently Smoking? ☐ YES ☐ NO

If you quit smoking, how many years ago did you quit? \_\_\_\_\_  
Must be 15 years ago or less.

Do you have a personal history of lung cancer? ☐ YES ☐ NO Years since original diagnosis of lung cancer? \_\_\_\_\_

Are you currently undergoing surveillance for cancer that includes imaging? ☐ YES ☐ NO

### Insurance Information

Name of Insurance Provider \_\_\_\_\_

ID/Policy Number \_\_\_\_\_

Group Number (if applicable) \_\_\_\_\_

### (For Physicians) Referring Clinic / Provider Information

☐ CT Lung Screening

☐ Follow-up

Clinic Name \_\_\_\_\_

Clinic Contact Name \_\_\_\_\_

Clinic Address \_\_\_\_\_

( ) -  
Clinic Phone \_\_\_\_\_

Ordering Physician (print name) \_\_\_\_\_

( ) -  
Phone Number \_\_\_\_\_

National Provider Identifier (NPI) \_\_\_\_\_

( ) -  
Fax Number \_\_\_\_\_

### (For Physicians) By Signing This Order, You Are Certifying That:

- The patient has participated in a discussion about the potential risks and benefits of CT lung screening.
- The patient was counseled on the importance of adherence to annual screening, impact of comorbidities, and ability/willingness to undergo diagnosis and treatment.
- The patient participated in a shared decision making discussion including the importance of smoking cessation and/or maintaining smoking abstinence, including the offer of Medicare-covered tobacco cessation counseling services, if applicable.
- The patient is asymptomatic (no symptoms such as fever, chest pain, new shortness of breath, new or changing cough, coughing up blood, or unexplained significant weight loss).

☐ Patient meets screening criteria

Ordering Physician Signature \_\_\_\_\_

/ /  
Today's Date \_\_\_\_\_



## APPOINTMENT SCHEDULING

### EAST METRO

**651.632.5700** phone

**651.681.1280** fax

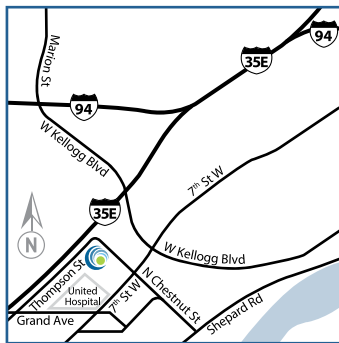
St. Paul

### WEST METRO

**763.792.1999** phone

**651.681.1280** fax

Coon Rapids, Maple Grove,  
Northwest, Burnsville



#### ST. PAUL - East Metro

Midwest Radiology Outpatient Imaging

250 Thompson Street

St. Paul, MN 55102

Phone: 651.602.7200



#### BURNSVILLE - West Metro

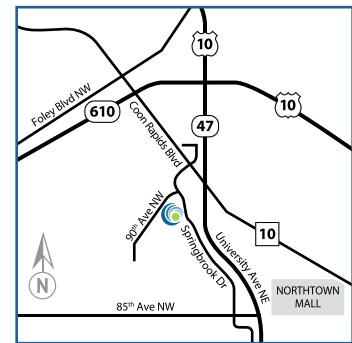
Midwest Radiology Outpatient Imaging

Burnsville Medical Center, Suite 204

14000 Nicollet Avenue S

Burnsville, MN 55337

Phone: 952.898.2333



#### COON RAPIDS - West Metro

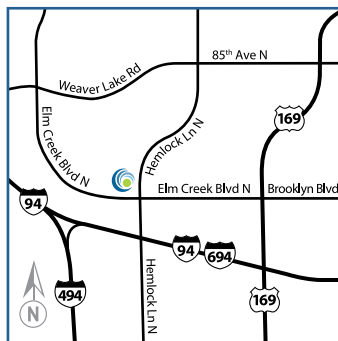
Suburban Outpatient Imaging

MMEC I, Suite 140

8990 Springbrook Drive

Coon Rapids, MN 55433

Phone: 763.792.1900



#### MAPLE GROVE - West Metro

Suburban Outpatient Imaging

Arbor Lakes Medical Building  
Suite 310

12000 Elm Creek Boulevard

Maple Grove, MN 55369

Phone: 763.416.7888



#### NORTHWEST - West Metro

Suburban Outpatient Imaging

Mercy Specialty Center, Suite 180

11850 Blackfoot Street NW

Coon Rapids, MN 55433

Phone: 763.795.1600

For detailed directions to each  
imaging center, please visit our website at  
[MidwestRadiology.com/us/locations-and-hours](http://MidwestRadiology.com/us/locations-and-hours)