MEDICAL SERVICES
PROVIDED BY RADIOLOGY
MEDICAL GROUP OF SANTA
CRUZ COUNTY, INC.

Low Dose CT Screening (LDCT) Referral Form

Referral is valid for 90 days
from date of request

Phone: (831) 476-7711
Fax (831) 476-6189
www.rmgscc.com

Appointment Date:______________________ Appointment Time: ____________ Arrival Time: ____________

Patient Name: ____ Phone #: ____________________

DOB:______________________ Height: _______________ Weight: ____________________________

Insurance: ________________________________ ID#: ________________ Auth #: ________________

Prior corresponding studies at: ___________________________________ Date of Studies: _______________
(Please have patient bring us prior studies and reports)

Referring Physician:____

Referring Physician Signature:____________________________________ Date: ______________________

Phone #:____ Fax #: ____________________________

Report to additional physician(s): ____

❑ **CD** ❑ **REPORT ONLY**

LUNG CANCER SCREENING ELIGIBILITY	
Pack Year History:	30 or more pack years
Smoking Status:	Currently smoking or quit in last 15 years
Age:	55-77 (Medicare); 55-80 (CCAH, private insurers)
Asymptomatic:	No clinical signs/symptoms of lung cancer

30 Pack year history or more? ❑ **Yes** ❑ **No**
Packs/day (20 cigarettes/pack):
________ x years smoked: ________ = pack years: ________

Patient currently smoking? ❑ **Yes** ❑ **No**
If not smoking, how many years quit? ________

Is patient asymptomatic? ❑ **Yes** ❑ **No**
(No symptoms such as fever, chest pain, new shortness of breath, new or changing cough, coughing up blood, or unexplained significant weight loss.)

Has patient participated in a shared decision-making session during which potential risks and benefits of CT lung screening were discussed, was informed of the importance of adherence to annual screening, impact of comorbidities, and ability/willingness to undergo diagnosis and treatment should the patient be diagnosed with lung cancer? ❑ **Yes** ❑ **No**

Has patient been informed of the importance of smoking cessation and/or maintaining smoking abstinence, and has been offered Medicare-covered tobacco cessation counseling services, if applicable? ❑ **Yes** ❑ **No**

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, PLEASE NOTIFY US AT LEAST 24 HOURS IN ADVANCE

Santa Cruz
Comprehensive Imaging®

1685-B Commercial Way
Santa Cruz, CA 95065
Scheduling: (831) 476-7711
Fax: (831) 476-6189

Directions: From Soquel Drive, turn onto Mission Drive. Turn right into the parking lot behind Erik's Deli Cafe. Parking is to the left. Enter the building from the parking lot side.