REQUEST FORM

LOW DOSE CT LUNG SCREENING ACCESS PROGRAM

PROVIDED BY: Moffitt Cancer Center

Referral Date: _____ (Request valid for 90 days from referral date)

Patient Name: _____ DOB: _____

Patient Address: _____

Zip Code: _____ Patient Phone Number: _____

Name of Referring Clinic: _____

Name of Referring Provider: _____

Clinic or Provider Phone Number: _____

Patients who meet the following criteria may be eligible to receive an annual Low Dose CT Lung Screening at no cost.

Please indicate which lung cancer risk factors impact this patient: (check all that apply)

- ☐ Smoking History
- ☐ Personal Cancer History
- ☐ Strong family history of lung cancer (one or more first degree relatives)
- ☐ Radon or Occupational Exposure
- ☐ Disease History (COPD or pulmonary fibrosis)
- ☐ Other: _____

To qualify one must:

Meet all Financial Guidelines:

- ☐ No health insurance AND
- ☐ Live in Pinellas, Hillsborough, Pasco, or Polk County AND
- ☐ Not on a student or tourist Visa AND
- ☐ Meet the income guideline (<200% of FPL)

Meet all National Comprehensive Cancer Network (NCCN) Clinical Guidelines:

- ☐ Be asymptomatic with no hemoptysis, coughing up blood or unexplained weight loss
- ☐ Be 50 years of age or older
- ☐ Current or former smoker with a, 20 packs a year smoking history; as determined by: *pack year = total # of years smoked X # of packs smoked per day*

Provider signature below indicates that the patient meets the criteria to the best of your knowledge.

Provider Signature: _____

Please email any questions to LungScreening@Moffitt.org.

Patient or clinic should call Moffitt Cancer Center at 813-745-3980 to schedule the appointment and indicate that the patient has a screening access request form. Please fax the request form to 813-449-8077.

Patient, please bring this request form with you to your appointment. *Por favor traigan este formulario a su cita.*

1-888-MOFFITT (1-888-663-3488) www.Moffitt.org

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