

# Low Dose Computed Tomography (LDCT) Consent / Decision Aid

I, \_\_\_\_\_ Date of Birth \_\_\_\_\_

hereby authorize IPMC Medical Center to perform a Low Dose Computed Tomography (LDCT) scan of the chest to evaluate for lung nodules. The benefit of this test is to offer a good chance of finding lung cancer in its earliest and most curable stages. My healthcare provider has discussed with me the criteria for testing which includes age, signs/symptoms of lung cancer and smoking history.

## I am aware that the potential risks include:

- **False-positive results:** This means that the test result may suggest that there is a problem which, after further testing turns out NOT to be an actual problem. This is also known as “over-diagnosis”. There is a 24% chance that a lung nodule (“spot on your lung”) will be found in a person at high-risk for lung cancer. If a nodule is found, there is a 96% chance that it will NOT be a cancer.
- **Additional Testing:** If an abnormal result is found on the LDCT, additional tests could be ordered to determine the cause. **If you are opposed to further testing or treatment, you should not be screened.**
- **Radiation Exposure:** A LDCT scan will expose you to a radiation dose that is similar to getting 15 chest x-rays (1.5mSv). In comparison, a regular CT scan uses about 5-6 times that amount.
- **Emotional Stress:** The process of testing, waiting for the results, possibly finding a lung nodule or cancer and the need for follow-up care and its cost could be sources of anxiety for some patients. If you have concerns about these or other LDCT issues, please discuss with your provider.

## I further understand that:

- The LDCT looks for lung nodules but does not determine if the nodule is actually a cancer.
- It is recommended that a lung nodule found on an LDCT be managed by a team of physicians who specialize in the evaluation and treatment of lung nodules and lung cancer.
- I will receive a summary of the results in the mail and a copy of the results will be sent to my ordering provider who is listed on my LDCT order form.
- I may qualify for annual LDCT lung cancer screenings (yearly repeat exams) if I meet certain criteria and I have discussed this with my provider.

## I certify that:

- I have received information and counseling about stopping smoking – (ask if more information needed).
- I understand that the best way to prevent lung cancer is to stop smoking.
- I attended a Shared Decision Making visit regarding LDCT with my healthcare provider and agree to undergo testing. All of my questions regarding this screening have been answered to my satisfaction.
- I have received a copy of this consent form for reference and have discussed it with my provider.

Patient Name	Patient Signature	Date
Healthcare Provider Name	Healthcare Provider Signature	Date

**FAX completed order and consent to IPMC: 215-464-0805**

# LDCT Lung Cancer Screening Order/ Counseling and Shared Decision Making Visit Documentation Form

Provider, please complete all lines to meet Federal guidelines for Low Dose Computed Tomography (LDCT) lung cancer screening and criteria for Counseling and Shared Decision Making Visit

<b>Patient Name</b>	<b>Date of Birth</b>	<b>Phone</b>
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**Screening candidates must meet ALL of the following criteria:**

- Age 50-77 years old
- No signs or symptoms of lung cancer      Pack Year History # \_\_\_\_\_
- Smoking history of at least 20 pack years      Pack year history = Packs/day x years smoked – (Pack=20 cigarettes)

**Must check one:**       Current smoker       Quit smoking within the past 15 years  
**If quit, must specify date** \_\_\_\_\_

**Please check one:**       Initial Screen       Annual Screen

**Has the patient had a chest CT in the last 12 months (any type, LDCT or conventional)?**

- YES    If yes, provide date and place of service of last chest CT \_\_\_\_\_. *If yes, patient may not qualify for LDCT screening.*
- NO    If not IPMC, bring outside CD and report.

- I have discussed the information on the consent form with my patient and answered all of his/her questions.  
(The information on this consent form is a necessary part of the counseling)

**Smoking cessation – Please choose one:**

- I have counseled the patient on the importance of maintaining smoking cessation.
- I have provided to the patient smoking cessation and/or abstinence counseling and provided the decision aid of my choice.
- Patient has used the following smoking cessation interventions(s): (i.e. gum, patches, meds, etc.)

Please list: \_\_\_\_\_

- I have discussed the importance of annual screening if my patient continues to meet the above criteria.
- My patient has the following comorbid conditions that may affect screening, further testing or treatment and were discussed with the patient: \_\_\_\_\_
- I have documented in the beneficiary's medical record the items necessary for the lung cancer screening to proceed.
- Exam ordered: Low-dose CT scan (LDCT) for lung cancer screening, code 71271**  
**Indication: personal history of tobacco use Z87.891, current smoker F17.270, or former smoker F17.211**

<b>Ordering Clinician Name (printed)</b>	<b>Signature</b>	<b>Date</b>	<b>NPI#</b>
<b>Patient Signature</b>		<b>Date</b>	

**FAX completed order and consent to IPMC: 215-464-0805**  
**Patient must also present completed order and consent at time of screening**

- All patient criteria met     Patient has NOT had a chest CT in the last 11 months
- Order form complete with patient identifiers, ordering clinician's name and NPI#

<b>Appt Date/Time</b>	<b>Account #</b>	<b>Scheduler's Initials</b>
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