



Rescue Lung/Rescue Life Lung Screening Program

Will your patient need an Interpreter?
What type? _____

If your patient is deaf do they prefer:
Reading Lips? _____
Sign Language? _____

CT Scan of Chest for Lung Cancer Screening Order Form:

Please instruct patients to call 855.CT.CHEST (855-282-4378) to be screened prior to ordering the exam. Screenings are offered at the following locations:

- ___ Addison Gilbert Hospital, a member of Lahey Health
- ___ Lahey Outpatient Center, Danvers

Patient Name: _____ Date of Birth _____

Home Phone: _____ Work Phone: _____
Cell Phone: _____

Ordering Physician: _____

Phone: _____ Fax: _____

PLEASE CHECK:

- Initial or Annual CT Chest for lung screening
- 3 month follow-up CT Chest for lung screening
- 6 month follow-up CT Chest for lung screening

History:

PHYSICIAN SIGNATURE: (no stamps please)

_____ Date _____ Time _____

Please fax to Beverly Hospital Central Scheduling at 978-712-1419 and/or instruct the patient to bring this to their appointment.

A SCREENING DOES NOT OBLIGATE YOUR PATIENT TO RETURN TO A BEVERLY HOSPITAL FACILITY FOR ANY FURTHER SCREENINGS, FOR FURTHER EVALUATION OF ANY FINDINGS, OR FOR ANY OTHER SERVICES THAT BEVERLY HOSPITAL PROVIDES.