Follow-Up Form

Follow-up Date
(DD/Mmm/YYYY)

Date of Baseline CT
(DD/Mmm/YYYY)

Time Since Baseline (Months)

Coordinator

Ordering Information

Ordering information is required **ONLY** for Medicare/Medicaid patients.

Was a CT lung screening scan ordered for this patient (CPT code G0297)? ○ no ○ yes (if no, the rest of the questions in this section are optional)

Ordering Practitioner First Name

Last name

NPI

Search

Documentation of shared decision making ○ no ○ yes (shared decision making is required for reimbursement for G0297 exams on baseline **only**)

Ordering practitioner reported smoking status: ○ current ○ former

Ordering practitioner reported pack years

Ordering practitioner reported years since quit (only required for former smokers)

Ordering practitioner reported asymptomatic for lung cancer: ○ no ○ yes

Clinical information
(information will be copied to CT report)

Have you taken antibiotics since your last CT scan? ○ no ○ yes **If so, when?** (Mmm/YYYY)

Is this an annual CT scan? ○ no ○ yes

Which year did you last have a prolonged exposure to secondhand tobacco smoke?

If you cannot remember, was it ○ less than 5 years ago, ○ more than 5 years ago, or ○ more than 10 years ago?

During the past year, have you experienced any of the symptoms listed below? ○ **no** ○ **yes (check all that apply)**

☐ cough producing bloody material, ☐ unexplained weight loss greater than 20 lbs, ☐ unexplained hoarseness

☐ other (specify)

If yes, have you seen a physician for this? ○ no ○ yes **Whom?**

If yes, are you now experiencing them? ○ no ○ yes

When did you most recently have a chest CT? -

If so, where was the test done?

Have you been hospitalized in the past year? ○ no ○ yes

If yes, for what?

When? (Mmm/YYYY)

Where?

Have you had a diagnosis of cancer in the past year? ○ no ○ yes

If yes, what part of body? -

Other (specify)

When were you diagnosed? (Mmm/YYYY)

If lung cancer has been diagnosed, have you had surgery? ○ no ○ yes

When? (DD/Mmm/YYYY)

Where?

If a lung cancer has been removed, is there evidence of recurrence? ○ no ○ yes

If yes, describe:

Smoking

Over the past month, have you smoked cigarettes at all, even a puff? ○ no ○ yes ○ never smoked

If yes, on average, on how many days per week are you currently smoking cigarettes?

On average, on the days that you are smoking cigarettes, how many packs of cigarettes are you currently smoking per day (PPD)?

If no, when was the date of your last cigarette (DD/Mmm/YYYY)? - -

Since your prior CT scan, have you ever tried to quit smoking? ○ no ○ yes ○ n/a

If yes, how many times have you quit smoking for at least 24 hours?

Since your prior CT scan, what, if any, smoking cessation methods have you used? (check all that apply)

- ☐ Have not tried to quit
- ☐ "Cold Turkey" by completely stopping on your own with no other assistance
- ☐ Tapering or reducing number of cigarettes smoked per day
- ☐ Self-help material (e.g., brochure, cessation website)
- ☐ Individual consultation or cessation counseling
- ☐ Telephone cessation counseling hotline (e.g., NY Smokers' Quitline)
- ☐ Peer support (e.g., Nicotine Anonymous)
- ☐ Nicotine replacement therapy (e.g., patch, gum, inhaler, nasal spray, lozenge)
- ☐ Zyban
- ☐ Hypnosis
- ☐ Acupuncture / acupressure
- ☐ Other (specify)

Other (specify)

Are you seriously thinking of quitting smoking? -

Smoking cessation materials were distributed to subject ○ no ○ yes

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Health Survey

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities.
Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.
For each of the following questions, please choose the one option that best describes your answer. ☐ RTA

1. Overall, how would you rate your health during the **past 4 weeks**?

Excellent	Very good	Good	Fair	Poor	Very Poor
○	○	○	○	○	○

2. During the **past 4 weeks**, how much did physical health problems limit your usual physical activities(such as walking or climbing stairs)

Not at all	Very little	Somewhat	Quite a lot	Could not do physical activities
○	○	○	○	○

3.During the **past 4 weeks**, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health?

None at all	A little bit	Some	Quite a lot	Could not do daily work
○	○	○	○	○

4. How much bodily pain have you had during the **past 4 weeks**?

None	Very mild	Mild	Moderate	Severe	Very Severe
○	○	○	○	○	○

5. During the **past 4 weeks**, how much energy did you have?

Very much	Quite a lot	Some	A little	None
○	○	○	○	○

6. During the **past 4 weeks**, how much did your physical health or emotional problems limit your usual social activities with family or friends?

None at all	Very little	Somewhat	Quite a lot	Could not do social activities
○	○	○	○	○

7. During the **past 4 weeks**, how much have you been bothered by **emotional problems**(such as feeling anxious, depressed or irritable)?

Not at all	Slightly	Moderately	Quite a lot	Extremely
○	○	○	○	○

8. During the **past 4 weeks**, how much did personal or emotional problems keep you from doing your usual work, school or other daily activities?

Not at all	Very little	Somewhat	Quite a lot	Could not do daily activities
○	○	○	○	○