UMC
UNIVERSITY MEDICAL CENTER

* P H Y O R D *

SCREENING PULMONARY ONCOLOGIC TUMOR SERVICES (SPOTS) PROGRAM REFERRAL

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PLACE PATIENT LABEL TO COVER OR COMPLETE BELOW:

Patient Name:_____

DOB:_____ Age:_____ Sex:_____

Account #:_____

Med Rec #:_____

INSTRUCTIONS: Please fill-in all requested data below and FAX this form with all relevant clinical notes and a copy of the patient's insurance card to 702-383-2288. Please call 702-667-7687 (702-NOSPOTS) with any questions.

US Preventative Services Task Force Criteria for Lung Cancer Screening *with Low Dose CT Scan*	
ALL of the following criteria MUST be met:	**Do NOT refer for screening if any of the following are true:**
❑ Patient's age is between 55 – 80 years old	❑ Patient has not smoked for the last 15 years
❑ Patient smokes ≥ 30 packs per year	❑ Patient develops health problems that limit life expectancy
❑ Current or previous smoker that has quit within 15 years	❑ Patient is not a candidate for curative lung surgery

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth:_____ Age:_____ Sex: ❑ Male ❑ Female Social Security #:_____

Address:_____ City:_____ State:_____ Zip:_____

Home #:_____ Cell #:_____ Other #:_____

INSURANCE INFORMATION

Insurance Carrier:_____ Policy #:_____ Group #:_____

Subscriber's Name (Last, First MI):_____ ❑ *Same as patient above*

Does this Insurance Carrier require prior authorization? ❑ Yes ❑ No

↳ If yes, Authorization #:_____ Date & Time Authorization Received:_____

REFERRAL INFORMATION

Patient Type: ❑ ED Patient ❑ Out-Patient ❑ In-Patient

Reason for Referral: ❑ Lung Cancer Screening → Low Dose CT Scan completed? ❑ Yes ❑ No

❑ Lung Nodule ❑ Newly Diagnosed Lung Cancer ❑ Abnormal Chest Imaging

❑ Other:_____

Brief History:

Diagnosis:_____

Test Results:_____

PROVIDER AUTHORIZATION

Instructions: This section is to be completed by the Primary or Requesting Provider.

Print Name:_____ ID #:_____ Phone #:_____

Time:_____ Date:_____ Physician Signature:_____