CHW:_____
Event:_____
Date:_____

TEXAS A&M UNIVERSITY HEALTH

Texas A&M Health Family Care • 2900 E 29th Street • Bryan • Texas • 77802 • 979 776 8440 (P) • 877 601 5854 (F)

Lung Screening- 979 436 0499

CPRIT Lung Grant Self-Referral Form

All fields must be completed

Patient Name on ID: _____ DOB (MM/DD/YYYY):_____

Preferred Name:_____ Phone #1:_____ ☐ Home ☐ Cell

Mailing Address:_____ Phone #2:_____ ☐ Home ☐ Cell

City:_____ County:_____State:____ Zipcode:_____ Preferred Language:_____

Gender (circle one): Male / Female Height:_____Weight:_____ Allergies: _____

Race: _____ Ethnicity (circle one) Hispanic / Non-Hispanic

1. Do you have any of the following? (check all that apply) □ fever □ chest pain □ new shortness of breath
   □ new or changing cough □ coughing up blood □unexpected significant weight loss
2. Have you had a chest CT in the last 12 months? □ Yes □ No

Smoking History: □ Current □ Former If former, # of years since quitting: _____

□ # of years smoked_____ # Packs per day _____ Total pack years _____ (must be ≥ 30 pack years)

Are you enrolled in smoking cessation program? □ Yes □ No If yes, name of program: _____

Are you insured? Yes / No Medicare? Yes / No Insurance Carrier _____

Group #_____ Member ID #:_____ Insurance Phone # _____

Do you have a Primary Care Provider that you would like to receive these results?

Provider Name _____Provider Contact Information_____

To be completed by Clinic Community Health Worker:

Shared Decision Making Office Visit Completed Date: _____ Completed by: _____