

CT LUNG SCREENING ORDER FORM

Patient Name: _____ DOB: mo / date / yr Patient Phone #: _____

Date/time of exam: _____ Height: _____ Weight: _____ BMI: _____

LUNG SCREENING EXAM (SELECT ONE): ☐ Initial Lung Screen Exam ☐ Subsequent exam

- Packs/day (20 cigarettes/pack): _____ x Years smoked: _____ = Pack years*: _____ (*Pack year calculator: <http://smokingpackyears.com/>)
- Currently smoking: Y or N
- If not currently smoking, how many years since stopped? _____

Patient insurance: _____ Authorization number: _____

For all insurance companies, authorize using the code: 71271 **CT Low Dose Lung Screening.**

The patient must meet ALL the following requirements to be eligible for the CT Lung Screening Program.

If the patient does not meet the following criteria, would they like to proceed as a self-pay?

Patient Agreement to Self pay: _____ Date: _____

- The patient has participated in a shared decision-making session during which potential risks and benefits of CT lung screening were discussed, was informed of the importance of adherence to annual screening, impact of comorbidities, and ability/willingness to undergo diagnosis and treatment should the patient be diagnosed with lung cancer. The patient was informed of the importance of smoking cessation and or maintaining smoking abstinence.
- The patient is between the ages of 50 - 80 years
- Is a current smoker or has quit within the past 15 years
- Has at least a 20+ pack year smoking history
- THE PATIENT IS ASYMPTOMATIC OF LUNG CANCER. **I attest the patient does not have and is not being treated for any of the following:** significant chest pain, unintended weight loss, hemoptysis, active pneumonia, no personal history of lung cancer, does not require home oxygen and has not received treatment or had evidence of any cancer other than non-melanoma of the skin in the past 5 years.

Ordering Provider Signature: _____ Date: mo / date / yr

Ordering Provider (print name): _____ Phone: _____

Ordering Provider NPI #(required): _____ Fax: _____

By signing this order, you are attesting that the patient meets all the above required elements, a shared decision-making visit has occurred and required elements are documented in the office notes.

Complete this order for all patients. Questions? Please call (515) 226-9810. Fax order: (515) 226-8408.