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If Exam requested has an asterisk, decision info is required.

*Decision Support Vendor _____

*Decision Support Adherence ☐ Yes ☐ No
☐ No criteria available

LOW-DOSE CT LUNG SCREENING ORDER

Patient Name: _____ DOB: _____ Date: _____
Patient's Phone: _____ Height: _____ Weight: _____ ☐ Male ☐ Female
Patient's Insurance: _____

(ALL fields on form must be completed)

Lung Cancer Screening Exam: ☐ BASELINE **OR** ☐ ANNUAL

☐ AGE: 50 - 80 years (Medicare Coverage/Other Insurance Coverage)

☐ Current **OR** ☐ Former Smoker (quit within the last 15 years) Year quit smoking: _____

Smoking History: Must be equivalent to smoking pack/day for a **MINIMUM of 20 PACK-YEARS**

HISTORY: Nbr of Packs/Day: _____ **X Nbr of Years Smoked** _____ **= Pack-Years** _____
(1 pack = 20 cigarettes) (Pack-years must equal 20+ to be eligible.)

BY SIGNING THIS ORDER, YOU ARE CERTIFYING THAT THE PATIENT IS:

- ASYMPTOMATIC: **NO signs or symptoms of lung cancer.** (Patients with symptoms may need a diagnostic CT)
- The patient was informed of the importance of smoking cessation and given smoking cessation education.
- The patient and the provider had a shared decision-making conversation DOCUMENTED regarding the risks and benefits of a LDCT scan.
- The patient must NOT have had a chest CT in the last 12 months

CPT CODE: 71271

(select a diagnosis) ☐ ICD10 CODE: Z87.89 **Diagnosis: Personal history of smoking**
☐ ICD10 CODE: F17.210 **Diagnosis: Nicotine Dependence**

ORDERING PROVIDER (PRINT): _____ NPI#: _____

OFFICE PHONE: _____ OFFICE FAX: _____

PROVIDER'S SIGNATURE: _____ DATE: _____

Please Fax: ☐ This Order
☐ Demographics
☐ Last Office Notes
☐ Last CT Scan Results (if applicable)

FAX NUMBER: 214-345-1885