Texas Health Presbyterian Hospital® PLANO

972-981-4070
Fax: 972-981-4071
❑ **Send CD**
6200 W Parker Rd.
Plano, TX 75093

Scan me to get location information

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)

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