

Lung Cancer Screening Order Form

For ordering questions, please call 843.529.0600

Patients who meet the following criteria can be screened for Lung Cancer with Low Dose CT

- Ages 50-80 years
- Asymptomatic (no signs or symptoms of lung cancer)
- Tobacco smoking history of at least 20 pack-years (pack years = # packs smoked per day x # of year smoked)
- Smokes currently or has quit within the last 15 years

Non-governmental coverage guidelines vary. Many require insurance preauthorization which should be obtained prior to scheduling. Note: Referring office must obtain insurance authorization for accepted Medicaid plans prior to scheduling.

All fields must be completed. Please call 843.529.0600 to schedule. Fax order to: 843.747.6565

Patients name: _____

Patients phone number: _____

Age: _____ **DOB:** _____ **Height:** _____ **Weight:** _____

Insurance plan: _____ **Group number:** _____

1. _____ packs/day x _____ years smoked = _____ pack years
2. Does the patient currently smoke? _____ If no, how long has it been since the patient quit smoking? _____
3. Does the patient have any signs or symptoms of lung cancer? _____
4. Has the patient participated in Lung Cancer Screening Program at another healthcare facility? _____
If yes, when and where: _____
5. Date of last lung screening? (if applicable) _____

_____ CT Lung Screening Low-Dose (use this for Baseline and annual screenings) (CPT 71271)

_____ CT Lung Screening Short-term follow-up (use only for follow-ups less than one year) (CPT 71250)

Comments: _____

Diagnosis Code (please choose one)

_____ F17.210 Nicotine dependence, cigarettes, uncomplicated

_____ F17.211 Nicotine dependence, cigarettes, in remission

_____ F17.213 Nicotine dependence, cigarettes, with withdrawal

_____ F17.218 Nicotine dependence, cigarettes, with other nicotine-induced disorders

_____ F17.219 Nicotine dependence, cigarettes, with other unspecified nicotine-induced disorders

_____ Z87.891 Personal history of tobacco abuse

_____ R91.1 Pulmonary Nodule (only use this code for Short-term follow-up exams)

By signing this order, you are certifying that:

- The patient has participated in a shared decision-making session (for initial screenings) during which potential risk and benefits of CT Lung Screening were discussed.
- The patient was informed of the importance of adherence to annual screening, impact of comorbidities, and the ability/willingness to undergo diagnosis and treatment.
- The patient was informed of smoking cessation and/or maintaining smoking abstinence, including the offer of Medicare-covered tobacco cessation counseling services, if applicable.
- The patient is asymptomatic for lung cancer.

Provider Signature: _____

Provider name printed: _____

Date: _____



Tricounty Radiology

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