

Use Ball Point Pen Only

CT Lung Screening Order Form
Fax to: 336-328-4415

To schedule an appt. please call 336-328-3333, Option#7
M-Th 7:30 am to 6:00 pm, Friday 7:30am-5:00pm

For **Pre-Registration** call 336-328-3733
Monday-Friday, 8:00 am to 6:00 pm

Patient Name: _____ DOB: ____/____/____

Patient Phone Number: _____

Screening Criteria

Patient must be between 55-77 years of age for Medicare or 55-80 for most private Insurance Carriers

Packs/day: _____ x Years smoked: _____ = Pack years: _____

(minimum 30 pack/yr history)

Currently smoking? Y N If not smoking, how many years quit? _____

(quit w/in 15 yrs.)

Symptomatic Y N

Insurance

_____ Medicare or Medicare Replacement

_____ All Other Insurance(s)

_____ ICD-10 Z87.891 – Personal History of Nicotine Dependence

Billing Codes

_____ CPT G0297

_____ CPT 71250

By signing this order, you are certifying that:

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

Print Name of Practitioner: _____ NPI: _____

Practitioner Signature: _____ Date: _____

Print Name:

Signature:

Date:

Time:



151110016
CTLUNG



Revised 01/2017
CT Lung Order Form