

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.)

**Patient must be asymptomatic. No signs or symptoms of lung cancer.**

**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:**



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Reviewed: 3/27/2018