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 50-77 years of age for Medicare or 55-80 for most private Insurance Carriers

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

(minimum 20 pack/yr history)(20 cigarettes/day x1 year=1 pack year)

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

(quit within the past 15 yrs.)

Symptomatic Y N (*No signs or symptoms of lung cancer)*

Insurance

_____ Medicare or Medicare Replacement

_____ All Other Insurance(s)

Billing Codes

_____ CPT G0297

_____ CPT 71250

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

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:_____Time_____

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Randolph Health

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