



Phone: 352-637-6100

Fax: 352-637-6900

2105 Highway 44 West, Inverness, FL 34453

Name: \_\_\_\_\_

Appt. Date/Time: \_\_\_\_\_ DOB: \_\_\_\_\_

Ordering Physician Printed Name: \_\_\_\_\_

### CT Lung Screening Order Form

Packs/Day (20 Cigarettes/pack): \_\_\_\_\_ Years smoked: \_\_\_\_\_ = Pack years\* \_\_\_\_\_

\*Pack year calculator: <http://smokingpackyears.com>

Currently smoking (F17.210)? Y N If former smoker (Z87.891), how many years since stopped? \_\_\_\_\_

CT LUNG SCREENING EXAM (Please select one): \_\_\_\_\_ INITIAL LUNG SCREENING EXAM

AUTHORIZATION\*#: \_\_\_\_\_ SUBSEQUENT EXAM

**\*Please authorize for ONE of the following codes:**

\_\_\_\_\_ **71271** CT LOW DOSE LUNG SCREENING

\_\_\_\_\_ **71250** CT THORAX WITHOUT CONTRAST (Use for 3 – 6 month Follow up only)

\_\_\_\_\_ **Z87.891** for former smokers (personal history of nicotine dependence)

\_\_\_\_\_ **F17.210** for current smokers (nicotine dependence)

### FAX COMPLETED ORDER FORM TO IMI: 352-637-6900

Comments: \_\_\_\_\_

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 co-morbidities, 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.
- The patient is between the ages of 50-80 years
- Has at least a 20+ pack year smoking history
- Is currently smoking or quit within the last 15 years(Stop screening once a person has not smoked for 15 years or has a health problem that limits life expectancy or the ability to have lung surgery).
- Has been at least **12 full months** from the date of the last screening.

I ATTEST THE PATIENT IS ASYMPTOMATIC OF LUNG CANCER AND THE PATIENT DOES NOT HAVE AND IS NOT BEING TREATED FOR: Fever, chest pain, new shortness of breath, new or changing cough, coughing up blood, or unexplained significant weight loss.

Ordering MD Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For more information about Low Dose Cancer Screening please visit:

<https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=364&ncdver=1&bc=AAAAGAAAAAAAAA==&>

<https://www.acr.org/Clinical-Resources/Lung-Cancer-Screening-Resources/FAQ>

[www.uspreventiveservicestaskforce.org](http://www.uspreventiveservicestaskforce.org).