

CT LUNG SCREENING ORDER FORM

For insurance submission, screening criteria* and completed form are required.

Patient Name: _____ MRN: _____ DOB: ____/____/____

Packs/day (20 cigarettes/pack): _____ x Years smoked: _____ = Pack years*: _____

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

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

***Screening Criteria:** Current smoker or former smoker, age 55-77, who has quit in the past 15 years and a smoking history of at least 30 pack years. A 30 pack year is defined as: One pack a day for 30 years or Two packs a day for 15 years.

Ordering MD (print name): _____ Phone: _____

National Provider Identifier (NPI): _____ Fax: _____

CT Lung Screening Exam (initial, repeat or follow-up)

Other _____

Please instruct patient to call **PERDIDO: 850.416.1892** or **TIGER POINT: 850.416.1894** to confirm eligibility when ordering the initial CT Lung Screening exam.

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 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.
- The patient is asymptomatic (no symptoms such as fever, chest pain, new shortness of breath, new or changing cough, coughing up blood, or unexplained significant weight loss).

Ordering MD Signature: _____ Date: ____/____/____

**Optimal
Imaging**

 **Sacred Heart
Health System**

Revised 10.8.2017

www.OptimalSacredHeart.com

CT ■ DEXA ■ MRI ■ Ultrasound ■ Wellness Imaging ■ Women's Imaging ■ X-Ray