Patient Label (Last, First, M DOB MRN)

Physician Order: CT Low Dose Lung Screening

Patient Name: _____DOB: ____/____/_____

CT LOW DOSE LUNG SCREENING EXAM:
(Please select one)
☐ Initial Lung Screening Exam
☐ Subsequent Exam

AUTHORIZATION # (if required):_____
Please authorize for the following CPT code:
☐ 71271

DIAGNOSIS CODE(S):
☐ CURRENT SMOKER: F17.210 Nicotine dependence, cigarettes, uncomplicated
☐ FORMER SMOKER: F17.211 Nicotine dependence, cigarettes, in remission
☐ OTHER/ADDITIONAL: _____

All fields below must be completed prior to scheduling of exam.

Is the patient 50-80 years of age (eligibility varies by payor).	☐ Yes ☐ No
Is the patient a current smoker? If not, **please indicate their quit date: _____** **Patients must have quit within the last 15 years.	☐ Yes ☐ No
Please indicate the pack-year smoking history. ***Pack year calculator: http://smokingpackyears.com/** Packs/day (20 cigarettes/pack) X Years smoked = Pack Years*	_____pk-yrs
For current smokers, was smoking cessation guidance provided to the patient from the provider?	☐ Yes ☐ No
Is the patient asymptomatic (no signs or symptoms of lung cancer such as chest pain, weight loss, hemoptysis, active pneumonia, etc.)?	☐ Yes ☐ No
If this is the patient's initial CT Lung Screening, has a shared decision visit occurred between the patient and the provider? * ***CMS requires that a shared decision-making visit occurs prior to the patient's initial CT Low Dose Lung Screening exam where specific information is acquired relating to the current and past cigarette use, the benefits and harms of CT Lung Screening, and counseling of tobacco cessation.**	☐ Yes ☐ No _____ Date of Visit (if applicable).

For patients to qualify for the Lung Cancer Screening Program, they must be between the ages of 55-80 (55-77 for Medicare), must be a current smoker or quit within the last 15 years, must have at least a 20 pack-year smoking history (varies by payor), must be asymptomatic of Lung Cancer, and have participated in a shared decision-making visit prior to initial LDCT screening. For any further questions, please call the CT Department at (802) 524-8447.

_____ _____ _____:_____AM / PM
Ordering Provider Signature Date Time

By signing this order, you are attesting that the patient meets all the above requirements, a shared decision-making visit has occurred and that these required elements are documented in office notes.

Ordering Provider (Print Name and Title):_____
NPI#_____ Phone#_____ Fax#_____

Please FAX completed order to (802)524-1289 and we will call the patient to schedule.