Lung Cancer Screening Program Order Form

Please choose Annual Screening **or** Follow-up

**PATIENT INFORMATION**

Last Name: First Name:

Phone: DOB:

**ANNUAL SCREENING ORDER** (Please include most recent chart notes)

Pack Years (must be minimum of 30. Pack years = packs per day x number of years smoked)

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

**Exam:**

* G0297 CT Lung Screening Exam (Initial or Subsequent Annual Screening)

**Diagnosis:**

* Z87.891 Former Smoker
* F17.210 Smoker

By signing this order, you are acknowledging the following eligibility for your patient:

* Asymptomatic **(no symptoms of lung cancer)**
* Between the ages of 55 and 80

**(Medicare/Medicare Managed Care patients age 78-80 are eligible for screening as self-pay)**

* The patient has participated in a Shared Decision Making session for their initial screening
* The patient was informed of the importance of smoking cessation and/or maintain smoking abstinence, and if appropriate, furnishing of information about tobacco cessation interventions.

**FOLLOW-UP ORDER** (Do not fill out the box below for an Annual Screening)

1

Previous LungRads Received: Date: **Recommended Follow-up Date:**

**DIAGNOSIS CODE:** (required on all orders)

LungRads 3 (6 Month Recommendation)

* Low Dose Chest CT – CPT 71250
* Other

LungRads 4A (3 Month Recommendation)

* Low Dose Chest CT – CPT 71250
* PET Scan - may be used when there is an equal to or greater than 8 mm solid component
* Other

LungRads 4B or 4X

* Chest CT with contrast – CPT 71260
* Chest CT w/o contrast (not Low Dose Chest CT) -

CPT – 71250

* PET Scan – may be used when there is an equal to or greater than 8 mm solid component
* Biopsy
* Other

**PROVIDER INFORMATION**

Ordering Provider: NPI:

Phone: Fax:

Insurance: Auth#:

Physician Signature: Date:

Please **fax** completed form to the Lung Cancer Screening Program at 503-814-1448

For questions, please call 503-814-1458