CT Lung Screening Order Form

Confluence HEALTH

Wenatchee Valley Hospital Fax: 509-664-3443
Moses Lake Clinic Fax: 509-764-6464

Pt. Phone Number: _____

Insurance: _____

Auth.#:_____Eligibility Dates: _____

Apply Scheduling Label Here

First Name: _____

Last Name: _____

Date of Birth: _____

History #: _____

CPT code: G0297 (Medicare); S8032 or 71250 (all other payors).

ICD-10 diagnosis code: Z87.891 (personal history of tobacco use/personal history of nicotine dependence),

Height:_____ Weight: _____

Age of patient _____ (Must be 55-77 years of age for Medicare patients, up to age 80 for private insurers.)

Currently smoking? ☐ Yes ☐ No If not smoking, how many years quit?_____

http://smokingpackyears.com/

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

Ordering MD (print name):_____ Phone: _____

National Provider Identifier (NPI): _____ Fax: _____

CT Lung Screening Exam: ☐ Initial ☐ Repeat ☐ Follow-Up

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:_____ / _____ / _____