CT Lung Cancer Screening Order Form

Wenatchee Valley Hospital Fax: 509-436-3001
Moses Lake Clinic Fax: 509-764-6464
Questions? 509-436-4028

Apply Scheduling Label Here

First Name: ____________________

Last Name: ____________________

Date of Birth: ____________________

History #: ____________________

Pt. Phone Number: ____________________

Insurance: ____________________

Auth.#:____________________Eligibility Dates: ______________

CPT code: 71271

Height:______________ Weight: ______________

Age of patient ________ (Must be 50-77 years of age for Medicare patients, up to age 50-80 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

● 20 pack year history ● Quit within 15 years ● Complete one shared decision making visit, details below

Comments: ____

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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:______ / ______ / ______