



CT Lung Cancer Screening Order Form

Mares Campus Fax: 509-436-3001

Moses Lake Campus Fax: 509-764-6464

Questions? 509-436-4028

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: _____

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: _____ / _____ / _____

Apply Scheduling Label Here

First Name: _____

Last Name: _____

Date of Birth: _____

History #: _____