CLEARVIEW CANCER
LUNG CANCER SCREENING

Low Dose CT (LDCT)
Lung Cancer Screening Physician's Order Form
LDCT Scheduling 256-327-5792
Please fax completed order to 256-327-9252

Patient Name: _____ Patient's Weight: _____ Height: _____

DOB: _____ SS Number: _____ Appt. Date & Time: _____

Patient Phone: _____ Location: ☐ **Huntsville Main Office** ☐ **Decatur Office** ☐ **Shoals Office**

Please choose:

Y	N	
☐	☐	Is patient 50-80 (insurance guidelines vary)?

Please check all additional risk factors that apply:

___ COPD ___ Emphysema ___ Coronary Artery Disease ___ Family History of Lung Cancer

___ **Personal** history of lymphoma, head, neck, and/or lung cancer

___ Occupational Exposure to: asbestos, arsenic, beryllium, cadmium, silica, nickel, and/or radon, diesel fumes

Screening Criteria *(Patient must meet all of the following criteria to be eligible)*

Y	N	
☐	☐	Verified patient has no signs or symptoms of Lung Cancer

_____ Enter the "Pack Years" of smoking history (numerical value).
*Must be 20 pack years (insurance guidelines vary)
(Pack Years = packs per day_____X_____years of smoking)

☐ ☐ Is patient a current smoker? *(If yes,ICD-10F17.210 - Nicotine dependence, cigarettes, uncomplicated)*

_____ Number of years since patient quit smoking **(Must be ≤15 years since quit; Enter 0 if current)**
(Years since quit) *(If former smoker ICD-10 Z87.891- Personal history of nicotine dependence)*
AND *ICD-10 Z12.2 - Encounter for screening for malignant neoplasm of respiratory organs*

Please select the appropriate order below

☐ **CT Lung Screening Initial (CPT 71271)**
I have discussed with the patient and documented in the medical record the shared decision making visit (office visit code:G0296) (eligibility, benefit and harm linked to LDCT screening, importance of annual LDCT and smoking cessation with resources). All questions have been answered.

☐ **CT Lung Screening Annual Follow Up (CPT 71271)** ***(One year must elapse between screenings)***

☐ **CT Lung Screening Diagnostic Evaluation (ICD-10 R91.8 Lung Mass)**
Please select contrast preference: ☐ Without (CPT code 71250) OR ☐ With (CPT code 71260)
(Diag. Eval. used only when less than a one year follow up is recommended on prior LDCT report)
(Lung-RADS3 - 6-month f/u; Lung-RADS 4A - 3-month f/u)

Provider Signature: _____ *Date & Time* _____
("Stamped signatures are not acceptable on any medical record" - CMS Transmittal #248)

Provider Name (printed): _____

Provider Phone: (_____) _____ Provider NPI: _____

☐ My office will provide results to the patient and schedule future screenings.

☐ I would like CCI to give results and schedule future annual lung screenings.