VANCOUVER CLINIC

CT Lung screening order form

Patient name: ______________________ DOB: ____/____/____ Phone: ______________________

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

Currently smoking? ☐ Y ☐ N If not currently smoking, how many years since patient quit? __________

LOW DOSE CT SCAN FOR LUNG CANCER SCREENING

You are ordering the lung cancer screening. This is a low dose CT without contrast.

Please indicate date of last CT (if applicable): ______________________

Authorization* number: ______________________ Date range: ______________________

*PLEASE AUTHORIZE FOR ONE OF THE FOLLOWING CODE:

☐ **71271** **CT THORAX LUNG SCREENING WITHOUT CONTRAST**

FAX COMPLETED ORDER FORM TO (360) 604-1694

The patient must meet all of the following elements for eligibility into the CT Lung screening program.

- The patient has participated in a shared decision making session during which potential risks and benefits of CT lung screening were discussed, was informed of the importance of adherence to annual screening, impact of comorbidities, and ability/willingness to undergo diagnosis and treatment should the patient is diagnosed with lung cancer, and 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 between the ages of 50-80 years
- Has at least a 20+ pack year smoking history
- Is currently smoking or quit within the last 15 years
- The patient is asymptomatic of lung cancer. **I ATTEST THE PATIENT DOES NOT HAVE AND IS NOT BEING TREATED FOR ANY OF THE FOLLOWING**:
  - » Significant chest pain
  - » Unintended weight loss
  - » Hemoptysis
  - » Active pneumonia

Ordering provider signature: ______________________ Date: ____/____/____

By signing this order, you are attesting that the patient meets all of the above required elements, a shared decision making visit has occurred, and required elements are documented in the office notes.

Ordering provider (print name): ______________________ Phone: ______________________

Ordering provider NPI **(required)**: ______________________ Fax: ______________________