McLaren PORT HURON

CONF_____

CT LUNG CANCER SCREENING ORDER FORM

1221 Pine Grove Avenue • Port Huron, Michigan • 48060 • Phone (810) 989-3270 • Fax (810) 987-6342

Patient's Name: _____ DOB:_____
(First) (Middle Initial) (Last)

Home Phone: _____ Cell Phone:_____

Appointment Date: _____ Time: _____

Physician Name (print name): _____Office Phone: ( ) _____

National Provider Identifier (NPI) _____ Office Fax: ( ) _____

Packs/Day: _____ x Years smoked: _____ = Pack years: _____ (Must be > 30 pack years)

Currently smoking? Y N If not smoking, how many years quit? (Must be < 15 years) _____

Height: _____ Weight: _____ SSN: _____

☐ **G0297 Screening CT exam for Lung Cancer**
*Please obtain prior authorization for insurances other than straight Medicare

- ☐ Initial
- ☐ Repeat
- ☐ Follow-Up

Diagnosis: ☐ Z87.891 Personal history of tobacco use/personal history of nicotine dependence

Please fax order to (810) 987-6342. Any questions please call the Nurse Navigator, (810) 987-5000 ext. 2090

By signing this order, you are certifying that:

- ☐ Patient is between the ages of 55-77.
- ☐ 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).
- ☐ Patient has not had a chest CT within the last 12 months

Physician Signature (Required):_____ Date: _____

5/2/16