# CT Lung Screening Order Form

**For insurance submission, screening criteria* and completed form are required.**

Patient Name: ________________________________ MRN: _________ DOB: ____/____/____

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

*Pack year calculator: http://smokingpackyears.com/

Currently smoking? ☐ Y ☐ N If not smoking, how many years quit? ________________________

***Screening Criteria:*** *Current smoker or former smoker, age 55-77, who has quit in the past 15 years and a smoking history of at least 30 pack years. A 30 pack year is defined as: One pack a day for 30 years or Two packs a day for 15 years.*

Ordering MD (print name): ________________________________ Phone: ____________________

National Provider Identifier (NPI): ______________________________ Fax: ___________________

☐ CT Lung Screening Exam (initial, repeat or follow-up)

☐ Other ______________________________________________________________

**Please instruct patient to call 864.885.0551 to confirm eligibility when ordering the initial CT Lung Screening exam.**

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: ____ /____ /____