EMORY
HEALTHCARE

Low Dose CT Lung Screening Order Form

To Schedule At All Locations: 404-686-LUNG (5864)
Order is Required at the time of Scheduling
Fax: 404-778-6657 E-mail: tecmd@emoryhealthcare.org

Date: _____/_____/_____ Time: _____

Medical Record Number (MRN):_____ **Patient Name** *(Last Name, First Name, MI):* _____ **Date of Birth:** _____ **Height:** _____ **Weight:** _____ ❑ **M** ❑ **F** **Insurance Plan/FSC:** _____ **Patient's Phone** *(H/W/Cell)*_____	*Required information needed to schedule:* **Ordering Provider Name (print)** _____ **NPI#:** _____ ***required per CMS*** **Office Phone:** _____ **Office Contact Name:** _____ **Contact Requesting Provider at:** _____

ICD-10 Code ALL CT Lung Screens: Z12.2 screening for malignant neoplasm respiratory organs

Circle others that apply:

Z72.0 Tobacco use **Z87.891** Personal history of nicotine dependence **Z80.1** Family history of malignant neoplasm *(trachea, bronchus, lung)*

Requirements for CT Lung Screening (CTLS)

Group 1: CMS / USPSTF Guidelines (Insurance Eligible)	Group 2: NCCN Guidelines (Self Pay)
• AGE: 55-77 years *(Medicare)* 55-80 years *(Other Insurance Carriers)* • Asymptomatic (NO signs or symptoms of lung cancer) • Current or Former Smoker • Smoking History: Equivalent to smoking pack/day for 30 yrs. (30 pack years) • Screening Duration: Screening should be discontinued once a patient has not smoked for 15 years or greater. ***Screening IS recommended following shared decision making including discussion of risks vs. benefits.***	• AGE: 50 years or older • Asymptomatic (NO signs or symptoms of lung cancer) • Current or Former Smoker • Smoking History: Equivalent to smoking pack/day for 20 yrs. (20 pack years) • One other lung cancer risk factor *excluding* second hand smoke • Screening Duration: Screening should be discontinued once a patient has not smoked for 15 years or greater. ***Screening NOT recommended, however, provider may order after shared decision making and discussion of risks vs. benefits of screening outside USPSTF defined high risk guidelines.***

PLEASE COMPLETE

Patient meets CTLS requirements (select one): ❑ YES (Group 1) ❑ YES (Group 2) ❑ No (see **note** below)

CT Chest Lung Screening w/o contrast (CPT: G0297): ❑ Baseline or ❑ Annual

Packs/day (20 cigarettes/pack) _____ x Years smoked: _____ = Pack Years _____
Currently Smoking? ❑ Y or ❑ No If not smoking, how many years since quitting? _____

Note: *Please call the CTLS Coordinator at 404-778-2039 when ordering the initial (baseline) CT Lung Screening exam with any questions or to verify screening eligibility.*

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).

Provider Signature (MD, DO, PA, and NP): _____ **Date:** _____ **Time:** _____

Scheduled Date: _____ Scheduled Time: _____ Location: _____