

## Low Dose Lung CT Screening Order Form

Patient: First \_\_\_\_\_

Ordering M.D.: \_\_\_\_\_

Last \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

Date of Birth:\* \_\_\_\_\_ (MM/DD/YYYY)

Physician Phone: \_\_\_\_\_

Packs per day (20 cigarettes per pack):\* \_\_\_\_\_

Physician Fax: \_\_\_\_\_

Years smoked:\* \_\_\_\_\_

**Comments:** \_\_\_\_\_

Packs per day x Years smoked = Pack years:\* \_\_\_\_\_

Pack year calculator:  
<http://smokingpackyears.com>

Currently smoking?\*  Yes  No

If not smoking, how many years since quitting?\* \_\_\_\_\_

**CT Lung Screening**

(Initial, Repeat, or Follow-up)

**Other**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### For both the initial and subsequent lung cancer screening services, a written order is required to include:

1. Beneficiary date of birth
2. Actual number of pack years smoked
3. Current smoking status, and for former smokers, the number of years since quitting smoking
4. Statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer), AND
5. National Provider Identifier (NPI) of the ordering practitioner

### BY SIGNING THIS ORDER, YOU CERTIFY 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 important 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 M.D. Signature: \_\_\_\_\_ Date: \_\_\_\_\_ (MM/DD/YYYY)