



## THE RADIOLOGY CLINIC

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### CT LUNG CANCER SCREENING ORDER FORM

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Phone #: \_\_\_\_\_

Packs/day (20 cigarettes/pack): \_\_\_\_\_ x Years smoked: \_\_\_\_\_ = **Pack years\***: \_\_\_\_\_  
\*Pack year calculator: <http://smokingpackyears.com/>

Currently smoking?  Yes  No If not currently smoking, how many years since stopped? \_\_\_\_\_

#### CT LUNG SCREENING EXAM (Please select one)

- CT LOW DOSE LUNG SCREENING BASELINE, CPT 71271 DX: Z87.891
- CT LOW DOSE LUNG SCREENING ANNUAL, CPT 71271 DX: Z87.891
- CT LOW DOSE CHEST – If Patient has ANY Symptoms or Does Not Meet Criteria, CPT 71250

List symptoms: \_\_\_\_\_

#### 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 be 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
  - Hemoptysis
  - Unintended weight loss
  - Active pneumonia

Ordering Provider (Print Name): \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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.**

**Order form given to Patient or Fax to TRC @ 301-217-0501**