CT Lung Screening Order Form

208 McFarland Circle, North
Tuscaloosa, Alabama 35406
Scheduling: (205) 345-2000
CT: (205) 345-4350

Patient Name: _____ MRN: _____ DOB: ____/____/_____

Packs/day (20 cigarettes/pack): _____ x Years smoked: ____ = Pack years*: _____
*Pack year calculator, http://smokingpackyears.com

Currently smoking? ☐☐ If not smoking, how many years quit? _____

Ordering MD (print name): _____ Phone: _____

National Provider Identifier (NPI): _____ Fax: _____

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

☐ Other _____

Comments: _____
_____

By signing this order, you are certifying that:

- 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).

And, if this is the patient's initial screening exam:

- 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.

Ordering MD Signature: _____ Date: ____/____/_____

Medicare Coverage Requirements:

- **Age 55-77 years (Blue Cross 55-80 years)**
- **No current signs or symptoms of lung disease**
- **Tobacco smoking history of at least 30 pack-years***
- **Current or former smokers who have quit within the last 15 years**

Counseling and shared decision making session must be clearly documented in the patient's chart.