WAYNE RADIOLOGISTS PA

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CT Lung Cancer Screening Referral Form

Patient Name: _____ **DOB:** _____ **Patient Phone #** _____

Patient Age: _____ (NOTE: Only patients 50-77 years old are eligible for screening.)

REQUIRED: Packs/day (20 cigarettes/pack): _____ X years smoked: _____ = Pack Years _____

REQUIRED (Choose One): Current Smoker? Y/N If former smoker, how many years since stopped? _____

Appointment Date: _____ **Appointment Time:** _____

CT LUNG SCREENING EXAM (Select one):

☐ **Low Dose CT Scan of Chest** (CPT 71271)
- ☐ Initial Lung Cancer Screening
- ☐ Annual Lung Cancer Screening

☐ **Follow-Up Low Dose CT Scan of Chest** (CPT 71250)
(Use this if a 3 - 6 month follow-up CT is recommended)

NOTE: PATIENT IS NOT ELIGIBLE FOR SCREENING IF THEY HAD A CT CHEST WITHIN THE LAST 12 MONTHS

AUTHORIZATION #: _____

Comments: _____

The patient must meet ALL the following requirements to be eligible for CT Lung Screening.

- 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, 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 old or 50-77 years old for Medicare patients.
- The patient has at least a 20 pack-year smoking history.
- The patient is currently smoking or quit smoking within the last 15 years.
- The patient shows no signs or symptoms of lung cancer and is not being treated for fever, chest pain, new shortness of breath, new or changing cough, hemoptysis, or unexplained weight loss.
- It has been at least 12 months from the date of the last screening.

By signing this form, you are attesting that the patient meets **ALL** the above requirements, a shared decision-making visit has occurred, and the required elements are documented in the patient's medical record.

Ordering Provider Signature: _____ Date: _____

Ordering Provider (print name): _____

Ordering Provider NPI: _____