206 W. Alexander Street, Suite 1
Plant City, Florida 33563

Scheduling: 813-750-1724
Fax to: 813-750-1971
Tax ID# 59-1262719

PCI
PLANT CITY IMAGING
Advanced radiology services where you live

CT Lung Screening Order Form

Patient Name: _____ DOB: _____ Patient Phone: _____

Packs per Day (1 Pack = 20 Cigarettes): _____ Years Smoked: _____ Pack Years: _____

Current Smoker? ❑ YES or ❑ NO If you're not a current smoker, how many years since you stopped? _____

Has a CT of the chest been performed in the last 12 months? ❑ YES or ❑ NO

If yes, when and where? _____

CT LUNG SCREENING EXAM REASON: Initial or Annual Lung Screening Exam (CPT codes: G0297 or 71271)

DIAGNOSIS: ❑ Nicotine dependence, unspecified, uncomplicated F17.200 ❑ Nicotine dependence, cigarettes, uncomplicated F17.210

❑ Personally history of nicotine dependence Z87.891 ❑ Encounter for screening for malignant neoplasm of respiratory organs Z12.2

COMMENTS: _____

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.

** Potential risks and benefits of CT Lung Screening were discussed.

** Patient was informed of the importance of adherence to annual screening, impact of co-morbidities, and has ability/willingness to undergo diagnosis and treatment should the patient be diagnosed with lung cancer.

** Patient has been informed of the importance of smoking cessation and/or maintaining smoking abstinence, including the offer of Medicare-covered tobacco cessation counseling services, if applicable.

Medicare and private insurance patients are 50 – 80 years old.

Patients have at least a 20+ pack year smoking history.

Patient is currently smoking or quit smoking 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 in the last 12 months
** Active Pneumonia in the last 3 months

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.

Ordering Provider Signature: _____ Date: _____

Ordering Provider Printed Name: _____ Date: _____

Ordering Provider NPI#: _____ Fax #: _____

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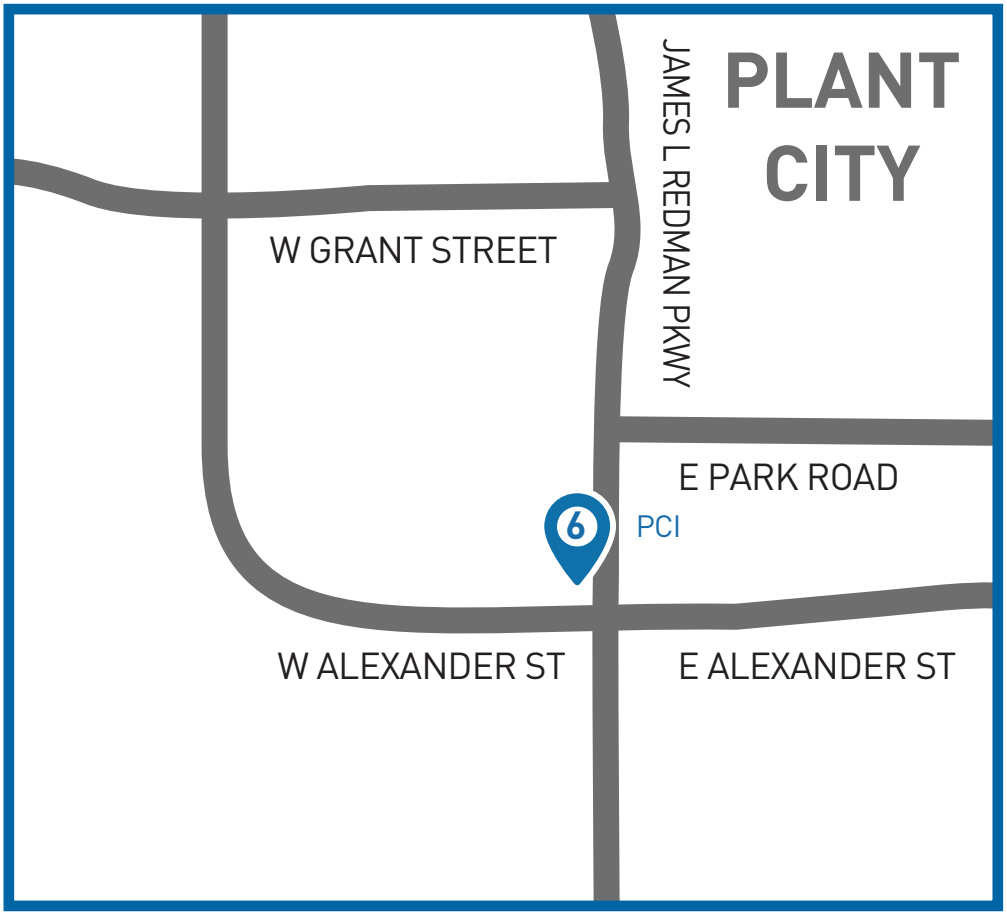

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CALL TO SCHEDULE OR CANCEL ANY EXAM

Appointment Date:_____ Time:_____