BARBARA ANN Karmanos

CANCER INSTITUTE

Wayne State University

CT Lung Cancer Screening Order Form

Patient Name:_____ Phone Number: _____ DOB:___/___/

___ Packs/day: _____x Years smoked: _____ = Pack years: _____ (Must be ≥ 20 pack years)

Currently smoking cigarettes? **Yes No** If not smoking, how many years quit? (Must be ≤ 15 years)

_____ Height: _____ Weight: _____

Ordering Physician (print name): _____ Phone: _____

National Provider Identifier (NPI): _____ Fax: _____

- ☐ Screening CT exam for Lung Cancer (Circle: Initial or repeat)
  (Diagnosis code: Z12.2, plus add the smoking status (F17.210 current smoker) (Z87.891 former smoker)
- ☐ Please obtain a prior authorization for insurances **OTHER** than straight Medicare, Medicaid, PHP, BCN, McLaren ("low dose CT for lung cancer screening -**71271**)
  Authorization number: _____
- ☐ **Please include a demographic sheet and fax to 313-576-9827 or Email: Screening@karmanos.org**
  Call 1-800-527-6266 with any questions.

By signing this order, you are certifying that:

- Patient is between the ages of 50-80.
- The patient has participated in a shared decision-making session during which potential risks and benefits of a 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.
- 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 Physician Signature: _____ Date: _____/_____ / _____