Beverly Hospital
A member of Lahey Health

Scheduling Phone: 866-479-3208 Scheduling Fax: 978-712-1419

☐ Addison Gilbert Hospital; Gloucester

☐ Lahey Outpatient Center; Danvers

CT Lung Screening Order Form

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

Packs/day (20 cigarettes/pack): _____ x Years smoked: _____ = Pack years*: _____

*Pack year calculator: http://smokingpackyears.com/

Currently smoking? Y N If not smoking, how many years quit? _____

Ordering MD (print name): _____ Phone: _____

☐ **G0297** CT Low Dose Lung **Screening** WO Contrast (**Initial or Annual**)

☐ **71250** CT Low Dose **Diagnostic Follow Up** WO Contrast (**3 month/6 month**)

Comments:

_____

_____

By signing this order, you are certifying that:

- 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.
- 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 MD Signature: _____ Date: ____/____/_____
(NO STAMPS PLEASE)

Authorization #: _____