Bay Medical Center
Sacred Heart Health System

Low Dose CT Lung Cancer Screening Order Form
Contact BMC Outpatient Scheduling for LDCT Cancer Lung Screening at (850) 747-6987
ORDER FORM LDCT

Patient Name: ___________________________ Date of Birth: ____________

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

Currently Smoking? □ Yes □ No Number of years since quitting smoking: ____________ years

Ordering Practitioner (print name): ___________________________ Phone: ____________

National Provider Identifier (NPI): ___________________________ Fax: ____________

Select one of the below:

□ Initial Low Dose CT Lung Screen (G0297)

□ Follow-up Low Dose CT Lung Screen (G0297)

Diagnosis / Indication:

□ Z 87.891 (Personal history of tobacco use/personal history of nicotine dependence)

□ Other: ________________________________________________

Criteria for exam (must meet all criteria):

- Age 55 - 77 years
- Smoking history of at least 30 pack-years
  o (one pack year = smoking one pack / day for one year; 1 pack = 20 cigarettes)
- Current smoker or one who has quit smoking within the last 15 years
- No chest CT scan within the past year
- Offered tobacco cessation counseling
- No signs or symptoms of lung cancer
- Shared decision making for this exam

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, the 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 Practitioner Signature: ___________________________ Date: ________

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