PUTNAM RADIOLOGY GROUP & THE WOMEN'S CENTER

Attention: Fax completed signed form to Scheduling. All incomplete forms will be returned.
***Putnam Radiology Group** • 6121 St Johns Ave • Palatka, FL 32177*
Phone: 386-326-0077 / Fax: 386-326-0188

Lung Screening Eligibility and Order Form

STEP 1: Demographics

Patient Name: _____ DOB: / / SSN: - -

Patient Phone #: ( ) - Allergies: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

Ordering Physician: _____ Physician Phone #: ( ) - Fax #: ( ) -

STEP 2: Eligibility

Individual must meet <u>all</u> criteria for Medicare Coverage

<u>Indications</u>

☐ Current smoker (F17.200)

☐ Former smoker (Z87.891) (must have quit within the past 15 years)

Number of years since quitting: _____

Packs/day (20 cigarettes/pack)**:** _____ X **years smoked:** _____ equals **Pack Years:** ☐

*(Requires **"YES"** to all of the following)*

• Age 55 - 77	☐ Yes	☐ No
• Currently a smoker or has quit within the past 15 years	☐ Yes	☐ No
• Has a ≥ 30 pack a year smoking history	☐ Yes	☐ No
• Asymptomatic (no signs or symptoms of lung cancer)	☐ Yes	☐ No
• If diagnosed, the patient is willing to undergo curative treatment	☐ Yes	☐ No

STEP 3: Order

<u>Order:</u> **CT Low Dose Lung Screening (without contrast)**

☒ **Low-dose computed tomography for lung cancer screening** (HCPCS: S8032/G0297)

By signing this order, you are certifying that:

- The patient has participated in a **shared decision making session** during which the potential risks and benefits of CT lung screening were discussed.
- The patient was informed of the importance of **adherence to annual screening**, impact of co morbidities, 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 offering of tobacco cessation counseling.
- 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)

Physician Signature _____ NPI (required) _____ Date _____