PUTNAM RADIOLOGY GROUP & 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
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:_____ Zip:_____

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

Step 2: Eligibility

Individual must meet all criteria for Medical Coverage

Indications

☐ Nicotine dependence, cigarettes, uncomplicated (Current smoker) (F17.210)

☐ 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:_____ = Pack Years

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

• Age 50 - 77	☐ YES	☐ NO
• Currently a smoker or has quit within the past 15 years	☐ YES	☐ NO
• Has a >20 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 2: Eligibility

Order: CT Low Dose Lung Screening (Without Contrast)

☒ **Low-does computed tomography for lung cancer screening** (Code 71271)

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 the 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 pan, new shortness of breath, new or changing cough, coughing up blood, or unexplained significant weight loss.)

Physician Signature _____ NPI (Required) _____ Date _____