20 Expedition Trail
Suite 102 (Lower Level)
Tel: 717-337-5991
Fax: 717-337-5995

CT Lung Screening Order Form

Patient Name:________________ **MRN:**______________ **DOB:**_____/_____/_____

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

***Pack year calculator: www.smokingpackyears.com**

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

Ordering MD (print Name):_____________________ Phone:_____________

National Provider Identifier (NPI):________________ Fax:_______________

- ☐ **CT Lung Screening Exam (initial, repeat or follow-up)**
- ☐ **Other** ___________________________________

Please instruct patient to call 717-337-5991 to confirm eligibility when ordering the initial CT Lung Screening Exam

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_______/_______/__________