



Radiology Request- CT CHEST LOW DOSE EXAM
Scheduling 540-332-4400 Fax 540-332-4490

Patient Name _____ Appt. Date/Time _____

DOB _____ Weight _____ Height _____ Phone _____

Insurance _____ Policy # _____ Group # _____

Pre-Auth Required: Y ___ N ___ Pre-Auth# _____ Packet Given: Y ___ N ___

Screening Criteria:

Medicare: ages 55-77 with at least 30 pack year cigarette smoking history and is a current smoker or has quit within the last 15 years

Private Insurers: ages 55-80 (this is an average age-depends on insurance coverage) with at least 30 pack year cigarette smoking history and is a current smoker or has quit within the last 15 years

PLEASE CHECK ONE:

Initial/Annual Screening Exam (71271) _____

Follow up Low Dose Diagnostic Exam (71250) (less than 12 months from screening) _____

Reason for Exam _____

Ordering Provider National Provider Identifier (NPI) _____

Smoking Pack-year history _____

Current smoker? Yes ___ No ___

If currently not smoking, number of years since quitting smoking _____

Has smoking cessation counselling been provided to patient? Yes ___ No ___

Provided by: Ordering Physician ___ Augusta Health 540-332-4988 ___

*****Smoking cessation counselling is required for insurance reimbursement*****

Is the patient experiencing any symptoms? Yes ___ No ___

***** Patient Must be Asymptomatic for Screening Exam Coverage*****

By signing this order you are certifying that:

- The patient has participated in a documented shared decision making session during which potential risks and benefits of CT Lung Screening were discussed;
- The patient was counseled on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities and ability or willingness to undergo diagnosis and treatment;
- The patient was counseled on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions; and
- The patient is asymptomatic (no symptoms such as fever, chest pain, new shortness of breath, new changing cough, coughing up blood, or unexplained significant weight loss).

If any questions in regards to this process, contact our CT Lung Cancer Screening Navigator at 540-332-5349 or 540-332-4885.

Physician Signature _____ **Date** _____ **Time** _____

Radiology Nurse Comments: _____

Radiology Nurse Review _____ **Date** _____ **Time** _____