PORT HURON

CONF__________________
- *Notify office of appt. date/time*

CT LUNG CANCER SCREENING ORDER FORM

1221 Pine Grove Avenue • Port Huron, Michigan • 48060 • Phone (810) 989-3270 • Fax (810) 987-6342

Patient's Name: ____ DOB:____________________
(First) (Middle Initial) (Last)

Home Phone: ____________________________ Cell Phone:_________________________________

Appointment Date: _________________________ Time: ____________________________________

Physician Name (print name): ____________________________Office Phone: ( ) ________________

National Provider Identifier (NPI) ___________________________ Office Fax: ( ) ___________________

Packs/Day: _______ x Years smoked: _______ = Pack years: _______ (Must be > 20 pack years)

Currently smoking? Y N If not smoking, how many years quit? (Must be < 15 years) _______

Height: _____________(inches) Weight: __________________ SSN: _____________________

☐ **71271 Screening CT exam for Lung Cancer**
*Please obtain prior authorization for insurances other than straight Medicare

☐ Initial
☐ Repeat
☐ Follow-Up

Diagnosis: ☐ Z87.891 Personal history of tobacco use/personal history of nicotine dependence

Please fax order to (810) 987-6342. Any questions please call the Nurse Navigator, (810) 989-3788

By signing this order, you are certifying that:

☐ Patient is between the ages of 50-77.

☐ 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).

☐ Patient has not had a chest CT within the last 12 months

Physician Signature (Required):_____________________________ Date: ______________