Kalispell
FAX: (406) 751-6752
To shedule: (406) 751-9729

LOGAN HEALTH

Whitefish
FAX: (406) 863-3676
Phone: (406) 863-3500

Lung Cancer Screening Order – Low Dose CT

Patient History:

Last Name , First Name:

Height: Weight:

Date Of Birth (MM/DD/YYYY):

Phone Number:

Insurance:
Medicare? (Please Circle) : Yes No

Other? (Please indicate):

Smoking History:

Are you currently smoking? (Please Circle): Yes No

If no, how many years since stopped? _____

A. How many years smoking? _____

B. How many packs per day? _____

PACK YEARS (years x pack per day): _____

SSN: _____

ANSWERS REQUIRED FOR ALL THE ABOVE OR TEST CANNOT BE PERFORMED

ALLERGIES? Yes No
If yes, indicate

REQUIRED - Diagnosis / History:

Please Select One:

- ☐ Baseline Lung Screening CT
- ☐ Subsequent follow up to Lung Screening CT

Designated imaging site:_____

The patient must meet ALL of the following elements for Medicare billing eligibility

The patient:

- Is between the ages of 50 and 77 years;
- Has =/+ 20 pack year smoking history;
- Is currently smoking, OR quit within the last 15 years;
- Is asymptomatic of lung cancer: THE PATIENT DOES NOT HAVE AND IS NOT BEING TREATED FOR ANY OF THE FOLLOWING: Significant chest pain, unintended weight loss, hemoptysis, and/or active pneumonia and acute bronchitis.
- Has participated in a shared decision making session, billed as CPT code G0296. During this session, 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 should the patient be diagnosed with lung cancer, and 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.

Ordering Provider Signature:_____ Date:_____/_____/_____

Ordering Provider (print): _____ Phone:_____

By signing this order, you are attesting that the patient meets all of the above required elements, a shared decision making visit has occurred, and any required elements are documented in the office notes.

ORDERING PROVIDER NPI #**_____ Fax: _____ ****Provider NPI number required**