RADIOLOGY ASSOCIATES of Tallahassee, P.A.

CDS/AUC: G-Code: _____ Modifier: _____

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DESIGNATED Lung Cancer Screening Center — AMERICAN COLLEGE OF RADIOLOGY

Low-Dose CT Lung Screen Order Form

Patient's Name _____ D.O.B. _____

Date of Counseling _____

Referring Facility _____

Facility Contact & Direct Line _____

Physician's Signature _____ **Date** _____

Printed Physician Name _____

National Provider Identifier _____

❑ Patient is between the ages of 50 and 77* *Patient's age* _____
**50 – 80 years old for commercial (non-Medicare) insurance*

❑ Patient currently smokes or stopped within 15 years

Current Smoker? _____Yes _____ No

If no, how many years since quitting? _____

❑ Patient has 20+ pack year smoking history*

_____ Packs/Day x _____ Years Smoked = _____ Pack Years (20 cigarettes/pack)

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).