Referral / Order: Low Dose CT (LDCT) Lung Cancer Screening Program

- Please fax completed form to our scheduling team at 907-714-4957 -

CMS Criteria (Must meet all 4)

- Age 50 – 77 years
- Asymptomatic (no signs or symptoms of lung cancer)
- Tobacco smoking history of at least 20 pack-years
- Current smoker or has quit smoking within the last 15 years

Patient Name: _____ Date of Birth: _____

Packs per day (20 cigarettes = 1 pack): _____ x Years smoked: _____ = Pack Years: _____
(Ex: 2 packs per day x 10 years smoked = 20 pack years)

Currently Smoking: ☐ Yes ☐ No – If not smoking, how many years since quitting: _____

Exam Information: (Choose One)

CT Lung Screening Exam

☐ Baseline (1st LDCT)

<OR>

☐ Annual (any subsequent LDCTs)

ICD 10 Code: (Choose One)

☐ Z87.891 Former Smoker (cigarettes)

<OR>

☐ F17.210 Current Smoker (cigarettes)

Ordering Provider Information:

Provider Name (Printed): _____ Phone: _____

National Provider Identification (NPI): _____ Fax: _____

By signing this order, you are certifying that:

- The patient has no signs or symptoms of lung cancer
- You have provided smoking cessation information with the patient/family (current smokers)
- You have provided shared decision making with patient/family (for baseline screening)
- The patient meets the four CMS criteria listed above

_____ _____ _____
Ordering Provider Signature Date Time

central peninsula imaging

Hours: Monday–Friday 8:00AM – 6:00PM
Scheduling: (P) 907-714-4420 (F) 907-714-4957