

Date of Call: \_\_\_\_\_ Prior Auth #: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ (55-80\*) Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Gender: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**(MC only)** Date of **Shared Decision Making** office visit (**G-0296-25**): \_\_\_\_/\_\_\_\_/\_\_\_\_ Completed by: \_\_\_\_\_

Did Provider offer **smoking cessation counseling and resources?** Yes No Unnecessary

Insurance: \*Commercial insurances cover ages: 55 - 80 (Aetna: 55 – 79); Medicare covers ages: 55 – 77

Insurance Carrier: \_\_\_\_\_ Member ID#: \_\_\_\_\_

Group # \_\_\_\_\_ Ins. Phone #: \_\_\_\_\_

Subscriber Name (if different from patient): \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

How patient heard about CTLS program: TV, Mailing, Radio, PCP, Pulmonologist, Other Specialist, Newspaper, Friend)?

Race (Caucasian, African Am, Asian, etc.): \_\_\_\_\_ Ethnicity (Hispanic or non-Hispanic): \_\_\_\_\_

**Exclusion Criteria:** 1. Has patient had a regular chest CT within the last 12 months? Yes \_\_\_\_\_ No \_\_\_\_\_

2. Does patient have lung cancer or any symptoms of lung cancer? Yes \_\_\_\_\_ No \_\_\_\_\_

**CT Screening Hx:** Is this the first (Baseline) CT Screening? Yes \_\_\_\_\_ No \_\_\_\_\_ OR Annual Screening? Yes \_\_\_\_\_ No \_\_\_\_\_

**Smoking History:** Current \_\_\_\_\_ Former \_\_\_\_\_ Age when first started \_\_\_\_\_ Total number of years smoking: \_\_\_\_\_

Number of packs per day: \_\_\_\_\_ Number of years since quitting (**must be <15 years**): \_\_\_\_\_

**Pack-year total\*:** \_\_\_\_\_ (**must be ≥30 pk-yrs.** \*Pack-year = # years smoked multiplied by # packs per day)

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Date: \_\_\_\_\_ **Physician Order - Low Dose CT for Lung Cancer Screening**

Ordering Provider's Name: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

**L'ville area locations:** \_\_\_\_\_ U of L'ville \_\_\_\_\_ Jewish Hosp. Downtown \_\_\_\_\_ Med. Ctr. East \_\_\_\_\_ Med. Ctr. NE

\_\_\_\_\_ Med. Ctr. South \_\_\_\_\_ Sts Mary & Eliz. Hosp. \_\_\_\_\_ Med. Ctr. SW \_\_\_\_\_ Flaget (Bardstown) \_\_\_\_\_ JH Shelbyville

**Eastern/Central KY:** \_\_\_\_\_ St Joe–Main \_\_\_\_\_ St Joe–East \_\_\_\_\_ BRI- East \_\_\_\_\_ BRI-West \_\_\_\_\_ St J. Richmond

\_\_\_\_\_ St J. Jessamine \_\_\_\_\_ St. J. London Hosp. \_\_\_\_\_ London Imaging Ctr. \_\_\_\_\_ St J. Martin \_\_\_\_\_ St. J. Mt Sterling

Appointment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ M T W TH F S Appointment Time: \_\_\_\_\_

 **Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**ICD- 10 Diagnosis Codes:** **287.891** Personal history-nicotine dependence (*former smoker*); **F17.210** Nicotine dependence, cigarettes, uncomplicated (*current smoker*);

**Procedure Code:** **HCPSC S-8032 (or G0297 for MC; may be used by commercial plans as well) Low Dose CT / Lung Cancer Screening**

Please fax this signed /dated order to Cancer Prevention Services

**502-210-4475**

Upon receipt of the signed / dated order, our Oncology Patient Coordinators will schedule this exam.

For all the latest CTLS forms, go to: <http://www.kentuckyonehealth.org/physician-order-ct-lung-screening>