Salem Health® Hospitals & Clinics

Lung Cancer Screening Program Order Form

Follow-Up Screening only, use separate for Annual

PATIENT INFORMATION

Last Name:_____ First Name: _____

Phone:_____ DOB: _____

☐ ANNUAL SCREENING ORDER

Pack Years_____(must be n ay x number of years smoked)

Currently Smoking? Y N If ot smoking, how many years quit? __

Exam:

- ☐ 71271 CT Lung Screening xam (Initial or Subsequent Annual Screening)
  - their initial creening
  - The patient was nformed of the importance of smoking cessation and/or aintain smoking abstinence, and if appropriate, urnishing of information about tobacco cessation nterventions.

Please do not complete this section for Follow-up Orders!

X FOLLOW-UP ORDER *(Do not fill out the box below for an Annual Screening)*

Previous LungRads Received:_____ Date:_____ **Recommended Follow-up Date:** _____

Diagnosis Code:_____(required on all orders)

Chest CT: ☐ Salem Health **OR** ☐ West Valley

LungRads 3 (6 Month Recommendation)

- ☐ Low Dose Chest CT – CPT 71250
- ☐ Other_____

LungRads 4A (3 Month Recommendation)

- ☐ Low Dose Chest CT – CPT 71250
- ☐ PET Scan - may be used when there is an equal to or greater than 8 mm solid component
- ☐ Other_____

LungRads 4B or 4X

- ☐ Chest CT with contrast – CPT 71260
- ☐ Chest CT w/o contrast (not Low Dose Chest CT) - CPT – 71250
- ☐ PET Scan – may be used when there is an equal to or greater than 8 mm solid component
- ☐ Biopsy
- ☐ Other_____

PROVIDER INFORMATION

Ordering Provider:_____ NPI:_____

Phone:_____ Fax:_____

Insurance:_____ Auth#:_____

Physician Signature:_____ Date: _____

Please **fax** completed form to Centralized Scheduling at 503-561-4723

For questions, please call 503-814-5293