CHI Saint Joseph Health Cancer Care | In affiliation with Cleveland Clinic Cancer Center

CHI Saint Joseph Resource Center P: 859.313.4673 F: 859.967.5587

Date of Call: _____ Prior Auth or Reference Call #: _____ EXP. DATE: _____

Name:_____ DOB: _____ Age: _____ (55 - 80; MC: 55 - 77)

Phone#:_____ Cell#:_____ Gender: **M F Ht:_____ Wt:_____**

Address: _____ City: _____ Zip: _____

Insurance Carrier:_____ Member ID#:_____

Secondary Ins:_____ Secondary ID#: _____

Insurance Phone #: _____ Subscriber Name (if diff from pt): _____

Exclusion Criteria: **Has the patient had a regular chest CT within the last 12 months? Yes _____ No _____**

If YES, what was the date of the last regular chest CT? _____

CT Screening Procedure Code: **G-0297** (Circle one) Baseline OR **ANNUAL**

Smoking Hx (cigarettes only): **C**urrent _____ (**F17.210, F17.211, F17.213, F17.218, F17.219**)

Former _____ (**Z87.891**)

Total # years smoked:_____ # Packs per day:_____ # Years since quitting(must be <15 yrs):_____

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

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Physician Order - Low Dose CT for Lung Cancer Screening (ATTENDING ONLY – RESIDENTS CANNOT ORDER)

Date:_____ **Ordering Provider's Name: _____**

Office Phone:_____ Office Fax:_____

Central/Eastern KY: ____ S J Hospital ____ S J East ____ BRI- Blazer ____ BRI-Bob O Link ____ S J Berea

____ Imaging - Richmond ____ S J Jessamine ____ Imaging - Winchester ____ S J Mt. Sterling

____ S J London ____ Imaging - London ____ Flaget Memorial Hospital (Bardstown)

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 has indicated the 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.

Physician Signature: _____ Date: ___/___/____

Physician NPI: _____

Please fax this signed /dated order to CHI Saint Joseph Resource Center: 859.967.5587

FOR RESOURCE CENTER TO SCHEDULE AND COMPLETE:

Scheduler Initials: _____ Appt Date: _____/_____/_____ M T W TH F S Appt Time: _____