CARTI LOW DOSE CT (LDCT)

Scheduling: 501.906.4454 | Fax: 501.907.8396 | Little Rock | North Little Rock | Conway | Pine Bluff | Russellville

LUNG CANCER SCREENING ORDER FORM

PLEASE ATTACH DEMO SHEET AND LAST OFFICE NOTE. Patient SSN: _____

PATIENT INFORMATION - Please print.

Patient Name: _____ DOB: _____ Phone: _____

Please check one of the following:

☐ **CT Lung Screening Initial -OR- 3-6 Month Follow-Up, As Needed***

- ☐ Participant confirms they have had a shared decision-making visit with their primary care physician.
- ☐ Defer to CARTI- Shared Decision-Making Visit (Eligibility, benefit and harm linked to LDCT screening, importance of annual LDCT and smoking cessation with resources). Program will report results to the initiating provider.

☐ **CT Lung Screening Annual Follow-Up**

**Only order if recommended by prior LS (LDCT) report: Lung-RADS 3, 4A or 4B; screening criteria not applicable.*

SCREENING CRITERIA

Patient must meet all criteria. Screenings can only be done once per year.

Y	N	
☐	☐	Is the patient between the ages of 50-80? *Do not order if patient is outside of these age ranges.*
☐	☐	Have you verified the patient has no signs or symptoms of lung cancer or has ever had lung cancer?

If the patient is a current or former smoker, enter the pack years of smoking history (numerical value).

_____Packs per day (Average # of cigarettes per day: 20 cigarettes = 1 pack)
_____Years of smoking
_____Pack-year score (# of packs/day X # of years smoked)

Must be 20 pack years or greater to be eligible for this scan. Do not order if pack year history is below the requirements as stated above.

☐	☐	Is the patient a current smoker? If yes, ICD-10 F17.210 Nicotine dependence, cigarettes, uncomplicated
☐	☐	Is the patient a former smoker? If yes, ICD-10 Z87.891 Personal Hx of Tobacco Use/Nicotine Dependence

Enter the number of years/date since patient quit smoking: _____
*For information purposes only, **not** eligibility criteria for screening.*

PRIMARY INSURANCE: _____ ID #: _____

ORDERING PROVIDER: _____ NPI#: _____

PHONE: _____ FAX: _____

PROVIDER SIGNATURE: _____ DATE: _____