ONCOLOGY SPECIALISTS OF CHARLOTTE

A Partner of OneOncology

CT LUNG SCREENING ORDER FORM

Authorization #: _____

Patient Name: _____ DOB: ____/____/____ Patient Phone#: _____

Packs/day (20 cigarettes/pack): _____x Years smoked: _____ = **Pack years***: _____

Currently smoking? ☐ **YES** ☐ **NO** If not currently smoking, how many years since stopped? _____

CT LUNG SCREENING EXAM (Please select one)

☐ CT INITIAL LUNG SCREENING (Technical Imaging Services Only)

☐ CT LUNG FOLLOW-UP SCREENING (Technical Imaging Services Only)

*Please authorize for ONE of the following codes:

G0297 CT LOW DOSE LUNG SCREENING OR **71250 CT THORAX WITHOUT CONTRAST**

****OSC will not be providing any professional services in connection with the selected screening. Results will be sent to the referring provider for interpretation and professional follow-up.**

HOW WOULD YOU LIKE RESULTS

☐ **FAX** Please provide fax #: _____

☐ **EMAIL** Please provide email address: _____

FOR OFFICE USE	
☐ I have confirmed the patient meets all eligibility criteria listed below, offered smoking cessation counseling & a shared decision visit occurred.	☐ Age 50-80 years *Insurance coverage may vary, CMS covers age 50-77.
☐ No signs or symptoms of lung cancer.	☐ Tobacco smoking history of at least 20 pack-years. Number pack-year smoked _____
☐ Current smoker or quit smoking within the last 15 years Number of years since quitting _____	☐ Patient has not had a chest CT scan in the past year.

CHARLOTTE
2711 Randolph Rd, Suite 400
Charlotte, NC 28207

DISCOVER THE **DIFFERENCE** IN CANCER CARE

Ph: 704.342.9577
Fax: 704.377.0353
charlotte**CAN**cer.com