Low Dose CT Navigator
210 Marie Langdon Drive
Manchester, KY 40962
Phone 606-598-5104 ext 4585 Fax 606-599-2523

Fax: _____ Date: _____

To: _____ Pages: _____

Re: _____ DOB: _____

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Thank you,

Clear Form

IF THERE ARE ANY PROBLEMS RECEIVING A TRANSMISSION, PLEASE CALL THE SENDER.

AdventHealth

LOW DOSE CT LUNG SCREENING

UNABLE TO SCHEDULE PATIENT

Patient Name: _____ DOB: _____

Patient Phone: _____

Dear _____

Thank you for the referral of your patient for the Low Dose CT Lung Screening.

Unfortunately, your patient has:

- ☐ Declined screening.
- ☐ Scheduled outside AdventHealth screening program .
- ☐ Has relocated.
- ☐ Insurance does not cover or insurance not accepted.
- ☐ Has not returned a phone call after at least 4 attempts to contact him/her to schedule.
- ☐ Patient no showed / canceled appointment _____

Therefore, we have not been able to schedule your patient for this Low Dose CT Lung Screening. Please contact me, Lisa Dobson, for any questions at 606-598-5104 ext. 4585.

_____ _____

Low Dose CT Navigator Date

Clear Form

AdventHealth

LOW-DOSE CT Lung Screening Registry

FOLLOW-UP EXAM ORDER

Patient Name: _____ **Phone Number:** _____

Patient Date of Birth: _____

☐ **Follow up Exam**

- ☐ **CT Chest without contrast**
- ☐ **CT Chest with contrast**
- ☐ **PET/CT Scan**
- ☐ **Other:** _____

Diagnosis Codes:

- ☐ **R91.1 Solitary pulmonary nodule**
- ☐ **R91.8 Other non-specific abnormal finding of lung field**
- ☐ **Other (Specify):** _____

Provider signature: **NPI#:** **Date:**

FAX ORDER TO: 606-599-2523 To Navigator for Scheduling

Clear Form

AdventHealth

LOW DOSE CT LUNG SCREENING

DOES NOT MEET CRITERIA AT THIS TIME

Dear _____

Thank you for the referral of your patient for the Low Dose CT Lung Screening.

Patient: _____ DOB: _____

In regards, to the order request for Low Dose CT Lung Screening, your patient does not meet screening criteria due to one of the following;

- ☐ (1) Does not meet age criteria; (age requirement 50-77 years old)
- ☐ (2) Is symptomatic;
- ☐ (3) Does not meet smoking history of at least 20 pack years for CMS.

  Pack years = 1 pack per/20 cigarettes day per year

  Example 1: 1 pack per day (20 cigarettes) for 30 years = 30 pack years

  Example 2: ½ per day (10 cigarettes) for 30 years = 15 pack years
- ☐ (4) Quit smoking more than 15 years ago
- ☐ (5) Had a CT Chest or Thorax within the past 12 months (Date: _____)

This patient is eligible for Screening on _____
We will schedule your patient at that time if they meet criteria.

_____ Date: _____

Low Dose CT Navigator

Clear Form

Lung Cancer Alliance
SCREENING CENTER OF EXCELLENCE
Offering Responsible Screening & Care

AdventHealth Imaging

PLEASE COMPLETE THIS FORM AND FAX IT BACK.

Low Dose CT Lung Screening Order Form

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Gender: ☐ Male ☐ Female

Patient Phone: _____ **Note: Must be 50-77 yrs old (CMS guidelines)**

SMOKING HISTORY

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

Note: Must be a minimum of 20 PACK YEAR HISTORY

Currently Smoking? YES ☐ NO ☐ If not smoking, number of years quit? ☐

Note: Must be 15 years or less

LOW DOSE CT LUNG SCREENING

Please choose one of the following diagnosis codes **(Must be completed.)**

☐ Z87.891 Personal history of nicotine dependence

☐ Z12.2 Screening malignant neoplasm respiratory tract (private insurance only)

☐ F17.211 Nicotine dependence, cigarettes in remission

☐ F17.210 Nicotine dependence, cigarettes, uncomplicated

BY SIGNING THIS ORDER YOU CERTIFY THAT:

- The patient has participated in a shared decision making session during which potential risks and benefits of low dose CT lung screening were discussed. *** For initial screening, provider may bill for shared decision making: G0296**
- The patient was informed of the importance of adherence to annual screening, impact of comorbidity and 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).**

Provider Name: _____ Phone: _____

Provider NPI: _____ Fax: _____

Provider Signature: _____ Date: _____

Fax order form to: 606-599-2523 | For questions call: 606-598-5104 ext. 4585

OFFICE USE ONLY

Patient is eligible for LDCT: Yes / No _____ _____

Navigator: *Date:*