MemorialCare
Saddleback Medical Center

Fax to Nurse Navigator: (949)380-4571

LOW-DOSE CT LUNG SCREENING ORDER FORM

Patient Name:		DOB:	
Patient's phone:		Ht/wt:	
Ordering MD (print):		Phone:	
NPI #:		Fax:	
Insurance:		**Authorization #:**	

Eligibility Criteria:

DX: ☐ Z87.891 Former Smoker ☐ F17.210 Current Smoker **(Please Check One)**

☐ Baseline Exam ☐ Follow-up Annual Exam

Age: _____ Patient must be 50-77 for Medicare reimbursement or 50-80 for most private insurance [Saddleback Medical Center Cash Price **$105.00**]

Packs/day (20 cigarettes/pack): _____ x **Years smoked**: _____= **Pack years**: _____
*(Must have ≥ 20 pack years.)

Current smoker: No / Yes **Former smoker**: # of years since quitting: _____
*(This number must be ≤15 years.)

Asymptomatic for lung cancer: Yes / No **(Please circle one)**
*Patients must be asymptomatic to meet eligibility criteria.

- CPT Code for LDCT lung screening: 71271 (or S8032 for some PPO/HMO)
- ***PLEASE PROVIDE INSURANCE AUTHORIZATION IF REQUIRED.**
- Screening exams are performed at Saddleback Medical Center, Main Hospital, 24451 Health Center Drive, Laguna Hills, CA 92653

By signing this order, you certify that:

- The patient has participated in and there is documentation of a shared decision-making session wherein potential risks and benefits, over diagnosis, false positives, radiation exposure and impact of comorbidities were discussed.
- The patient is able and willing to undergo screening and if necessary, diagnosis and treatment.
- The patient was informed of the importance of adherence to annual screening.
- The patient was informed of the importance of smoking cessation and/or maintaining smoking abstinence.

Provider Signature: _____ Date: _____

MemorialCare Saddleback Medical Center: Lung Screening Nurse Navigator
Phone: (949) 452-7416 **Fax: (949) 380-4571**