All Populations Physician Order Form – CT Lung Cancer Screening Annual (LDCT)	**McLeod Health** McLeod Healthy Lungs Initiative Program	Program Hub **Phone: 843-777-5953** Reservations & Scheduling **Fax: 843-777-6910**

Patient Name: _____ DOB: _____

Patient Phone Number: _____

Ordering MD/Provider: _____

Contact Phone Number: _____

Documentation Required for Eligibility Verification:

(Please circle or fill in answers to #1-5; if form is not completed entirely, patient may not be able to receive scan)

1. Age 50-80? Yes or No
   (Patient must be in this age range)
2. Current smoker? Yes or No
   If no, number of years since quit: _____
   (Must be 15 years or less)
3. Pack-year history: _____
   (Calculated by number of packs per day multiplied by number of years as smoker;
   Ex: 1 pack/day x 20 years = 20 pack-year history;
   Ex: 2 packs/day x 10 years = 20 pack-year history)
   (Must have at least a 20 pack-year history)
4. Patient is asymptomatic (no signs or symptoms) for lung cancer: Yes or No
5. Counseling and decision-making* occurred at provider's office with MD/NP/PA; included adherence to LDCT screening, cigarette smoking abstinence/cessation:
   Yes or No
   *Shared decision-making is required for baseline (initial) LDCT scans, but not for subsequent annual screening.

Exclusion Criteria:

- Chest CT in the past 12 months
- Symptomatic for lung cancer
  e.g. unexplained persistent cough, worsening of chronic cough, hemoptysis, chest pain of unknown origin, new hoarseness, and/or unexplained weight loss
- Lung cancer diagnosed within past 5 years
- Functional status or comorbidity prohibitive of curative intent

Physician order: (Check one)

☐	CT Lung Screening Annual (LDCT) F17.210: Current smoker, nicotine dependence, cigarettes, uncomplicated
☐	CT Lung Screening Annual (LDCT) Z87.891: History of smoking, personal history of nicotine dependence

If LDCT results are positive per NCCN and NLST guidelines: (Check one)

☐	Refer to McLeod Pulmonology: (please circle a location below) Florence or Loris-Seacoast
☐	Send the patient back to me; I would prefer to manage the patient's plan of care.

Provider Signature: _____ Date: _____ Time: _____

NPI Number: (required) _____

Revised: 06/2021