



Lisa Dobson, RN
Low Dose CT Navigator

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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,
Lisa Dobson, RN

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

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**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



Advent Health

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



Advent Health

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



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: