

Patient Information

Patient Name: _____ DOB: _____ Sex: M F SS #: XXX - XX - _____
First & Last Name

Patient's Address: _____
Street City State Zip Code

Home Phone #: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #: _____ Insurance Phone #: _____
Plan & Product

Secondary Insurance: _____ Policy #: _____ Group #: _____ Insurance Phone #: _____
Plan & Product

Order Information

Diagnosis: **Screening for Malignant Neoplasm of Lung** _____ ICD-CM Code: Z122
Provider Initials

F17.200 Nicotine dependence unspecified, uncomplicated OR Z87.891 Personal history of nicotine dependence _____
Provider Initials

Test/Service Desired: **Low-dose Computed Tomography of Chest** _____
Provider Initials

INITIAL SCREENING: I ordered this screening as a result of a lung cancer screening counseling and shared decision-making visit with the patient (G0296). _____; OR
Provider Initials

SUBSEQUENT SCREENING

Patient DOB: _____ Smoking history: _____ pack/years (_____ PPD x _____ yrs)

Current smoker, OR

Quit smoking _____ years ago Patient is asymptomatic (no signs or symptoms of lung cancer) _____
Provider Initials

Patient has following comorbidities/exposures:

COPD

Pulmonary Fibrosis

Personal history of cancer: lymphoma, lung, head and neck, bladder (circle appropriate condition)

Family history of lung cancer

Radon exposure

Occupational exposure to arsenic, asbestos, beryllium, cadmium, coal smoke, chromium, diesel fumes, nickel, silica or soot (circle appropriate exposures)

Referring Physician Information

Physician Name (first & last): _____ NPI #: _____ GA License #: _____

Physician Address: _____ Phone #: _____ Fax #: _____

I hereby certify that the services indicated in the above order form are medically necessary.

Physician Signature: _____ Date: _____ Time: _____



DeKalb Medical

FAX orders to: 404.501.1743
Phone: 404.501.SCHD (7243)
Tax ID Number 58-1966795

LUNG CANCER SCREENING ORDER FORM



PS - 1078

DMC FORM # PS-1078 (01/14/16)