



Scheduling: (603) 537-1363 x3403 | Fax: (603) 537-1324

Derry Imaging Center
6 Tsienneto Road, Suite 100LL, Derry, NH 03038

MRI & CT Center at Bedford
160 South River Road, Suite 1018, Bedford, NH 03110

LDCT Lung Screening Order Form (71271)

Patient Name: _____ **DOB:** _____

Address: _____ **Phone:** _____

Prior LDCT Lung Screening Yes No Where: _____ When: _____

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

Currently smoking? Y N If not smoking, how many years quit? _____

Ordering MD (print name) _____ Phone: _____

National Provider Identifier (NPI): _____ Fax: _____

Insurance: _____

Member ID# _____

Auth. Yes/No# _____

By signing this order, you are certifying that:

- The patient has participated in a shared decision making session during which potential risks and benefits of CT lung screening were discussed.
- The patient was informed of the importance of adherence to annual screening, impact of comorbidities, 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).

ICD 10 Code(s):

- Z12.2**
Encounter for lung cancer screening
- Z87.891** (former smoker) Personal history nicotine dependence
- F17.210** (current smoker) Nicotine dependence, cigarettes, uncomplicated
- F17.211** Nicotine dependence, cigarettes, in remission

Ordering MD Signature

_____/_____/_____

Date