LOW DOSE LUNG SCREENING ORDER

Fax Order to: (937) 293-6573
Phone: (937) 293-2273
NPI # 1487641585 First Dayton Radiation Oncology

Name:	DOB:	Age:
Phone:	Alt Phone:	
Insurance Name and Member ID:		
Prior Authorization #:	Dates Valid:	
Ordering Physician:	NPI:	
Office Phone:	Office Fax:	

□ **Please send most recent office note pertaining to reason for ordering LDCT.**

□ **Send a copy of insurance card.**

ICD-10: ☐ Z12.2 – Screening for Respiratory Organs ☐ Z87.891 Former Smoker	☐ F17.200 – Current Smoker ☐ Other:
Exam Requested: ☐ S8032 – Low Dose Helical CT Scan Lung Screening	
Date of last Screening:	☐ Initial Screening
Screenings are intended for patients who are **NOT** experiencing any symptoms. Is the patient currently experiencing any of the following symptoms: ***Cough, Shortness of Breath, Wheezing***:	☐ No ☐ Yes

Smoking History

(Required for eligibility determination)

☐ Current Smoker ☐ Former Smoker (Year Quit:_______)

Packs per day:_______ X # of Years:________ = ________ Pack-Years

______________________________________ ________________________

ORDERING PHYSICIAN SIGNATURE **DATE**