NOVELLO IMAGING
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Lung Cancer Screening Eligibility Form/Provider Order
*****ALL FIELDS REQUIRED*****

Patient Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

DOB: _____ Gender: _____

Height: _____ Weight: _____

Insurance: _____ Policy #: _____

Smoking Status	☐ Current Smoker ☐ Former Smoker
• If former smoker, years since quitting (MUST be ≤15 yrs)	Years since quitting smoking: _____
Pack Years: • Packs per day x Number of years smoking (must be ≥20)	Pack years of smoking: _____
Asymptomatic: No signs/Symptoms of lung cancer (ex: weght loss, fever, etc) • must be YES • If NO, order diagnostic CT	☐ Yes (asymptomatic) ☐ No (symptoms)
Tobacco cessation/abstinence counseling was provided • Must be YES	☐ Yes ☐ No
A decision-making session during which potential risk and benefits of CT lung screening were discussed • Must be YES	☐ Yes ☐ No
Patient was informed of the importance of adhering to annual screening, impact of comorbidities and ability/willingness to undergo treatment • Must be YES	☐ Yes ☐ No
History of prior Cancer • If YES, provide what type of cancer	☐ Yes ☐ No

CT Chest Lung Cancer Screening (Baseline or Annual Exam) CPT 71271

☐ Baseline ☐ Annual Date of last screening: (needs month/day/year) ___/___/____ *(must be at least 1 year and 1 day between screenings)*

ICD-10 code:

☐ Z87.891 Personal history of tobacco use/personal history of nicotine dependence
☐ F17.210 Nicotine dependence, cigarettes, uncomplicated

Ordering Provider: _____ NPI #: _____

Provider Signature (mandatory): _____

Date: _____

Primary Care Provider *(if different than ordering provider)* _____

PLEASE PROVIDE A COPY FOR THE PATIENT AND INSTRUCT THEM TO BRING IT TO THE APPOINTMENT WITH THEM.

REV 2/2025

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Fax completed form to Novello Imaging 231-714-0077

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