Columbus Regional HEALTHCARE SYSTEM

500 Jefferson Street Whiteville, NC 28472
Phone: 910-642-8011 ext. 2224
Fax: 910-642-1727

CT Lung Screening Order Form

Patient Name: _____ DOB: ____/____/____ Ht:_____ Wt:_____

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

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

Ordering MD (print name): _____ Phone: _____

National Provider Identifier (NPI): _____ Fax: _____

○ CT Lung Screening Exam Baseline (Initial)

○ CT Lung Screening Exam Repeat (Annual)

Please instruct patient to call 910-642-8011 ext. 2224 to confirm eligibility when ordering the initial CT Lung Screening exam.

Comments:

By signing this order, you are certifying that:

- The patient has participated in a shared decision making session during which potential risk 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).

Ordering MD Signature: _____ Date: _____ Time:_____