Valley Radiology

169 Rawls Road, Angier, NC 27501
Phone: (919) 331-2001
Fax: (919) 331-2003

Appointment Date: _____
Appointment Time: _____
Check In Time: _____

Low Dose CT Lung Screening Request Form

Having discussed with my patient, I request that my asymptomatic (no signs or symptoms of lung cancer) patient, _____, DOB_____, be scheduled for a Low Dose CT Lung Screening Scan at Valley Radiology.

Date of Shared Decision Making (SDM) counseling office visit to discuss lung screening: _____

Printed Name/Title of personnel conducting SDM counseling office visit: _____

Age: (55-77)_____

Pack Year History:_____ PPD X _____ Years.

Current Smoker? ☐ Yes ☐ No

If No, how many years ago did patient quit?_____

Referring Physician:

Print Name:_____

Signature: _____

NPI:_____

Date:_____ Contact #: _____

Diagnosis Code:

Z12.2 -Encounter for screening for malignant neoplasm of respiratory organs
Z72.0 -Tobacco use
Z87.891 -Personal history of nicotine dependence
Other: _____

Comments:_____

_____

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