IMAGING

THE QUEEN'S MEDICAL CENTER
PUNCHBOWL / WEST O'AHU

PUNCHBOWL SCHEDULING
Phone: 691-7171
Fax 691-7007

WEST O'AHU SCHEDULING
Phone: 691-3663
Fax: 691-3678

Your appointment is scheduled for:

Date:__________ Time:________ AM / PM

By:______________ Location: __________

☐ Please call patient to schedule

☐ The Queen's M edical Center - Punchbowl
☐ The Queen's Medical Center - West O'ahu

OUTPATIENT TESTING ORDERS

PATIENT INFORMATION

Patient's Name (Last, First, Middle Initial):	Date of Birth:	Phone:
Patient's Insurance(s):	Authorization #:	

☐ Language interpreter requested ______________________________

PROCEDURE(S) REQUESTED – Please specify body part(s)

☑ CT Lung Cancer Screening

1. Please check the appropriate box according to patient's insurance: ☐ Patient is between the age of **50 to 80*** ☐ Patient is between the age of **50 to 77 (Medicare only)** *This reflects the 2022 USPSTF guidelines
2. Is the patient asymptomatic (no signs or symptoms of lung cancer)? ☐ Yes ☐ No
3. Enter the number of pack-years smoked (cigarettes): ☐ >=20 pack-years _______ *This reflects the 2022 USPSTF guidelines (Calculation: Multiply # of packs of cigarettes smoked per day by the # of years the person has smoked. 1 pack-year = 1 pack/day x 1 year of smoking)
4. Is the patient a current smoker? ☐ Yes ☐ No
   If no, has the patient quit smoking within the last 15 years? ☐ Yes ☐ No (If yes, please complete #5)
5. How many years since the patient quit smoking? ___________ month _______ years
6. Is this an Initial or Follow-up referral for CT Lung Screening? ☐ Initial ☐ Follow-up
7. If initial referral, has the patient received counseling and shared decision making visit per CMS guidelines? ☐ Yes ☐ No
8. National Provider Identifier (NPI#) is required by CMS (Centers for Medicare & Medicaid Services), please enter below.

APPROPRIATE USE CRITERIA (AUC) CONSULTATION (effective 1/1/20) - MANDATORY FOR CT, MRI, NM, PET

Session ID# ______________	AUC Score ________	Vendor (qCDSM) ______________	Adherence ☐ Yes ☐ No ☐ N/A

DIAGNOSIS/SYMPTOMS/HISTORY (ICD-10 Mandatory)

"Rule Out" or "Routine" not acceptable

For date of service effective 10/1/2015 ICD-10 codes will be required

ICD-10 ________ **DESCRIPTION** ______________________________

Symptoms / History:

CC REPORT TO:

☐ Please call report to MD

☐ Patient to Return with CD

ORDERING PHYSICIAN CERTIFICATION

X ______________________________

By signature above, I hereby certify that the procedure(s) requested is/are medically necessary.

Print Physician Name:	**NPI #:**
Phone:	Fax:
Date:	Time: AM / PM

CONFIDENTIALITY NOTICE:
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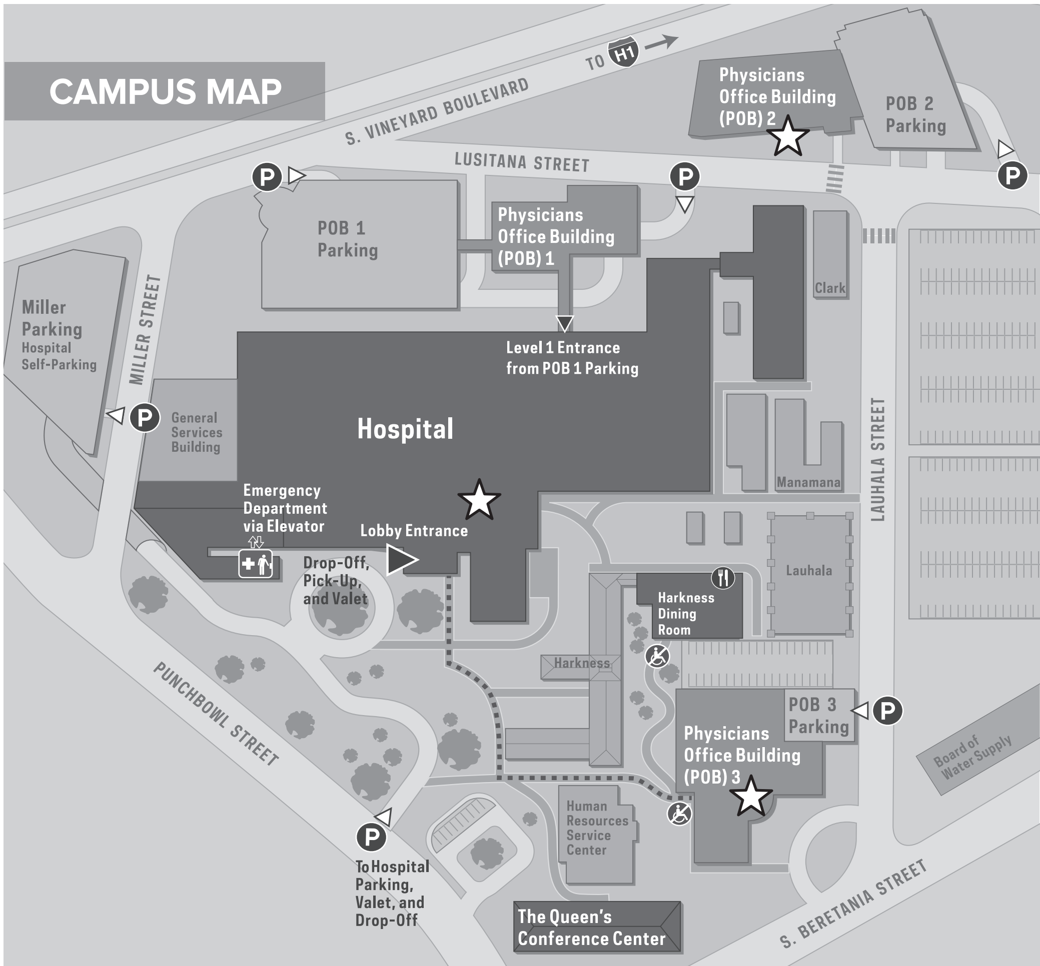
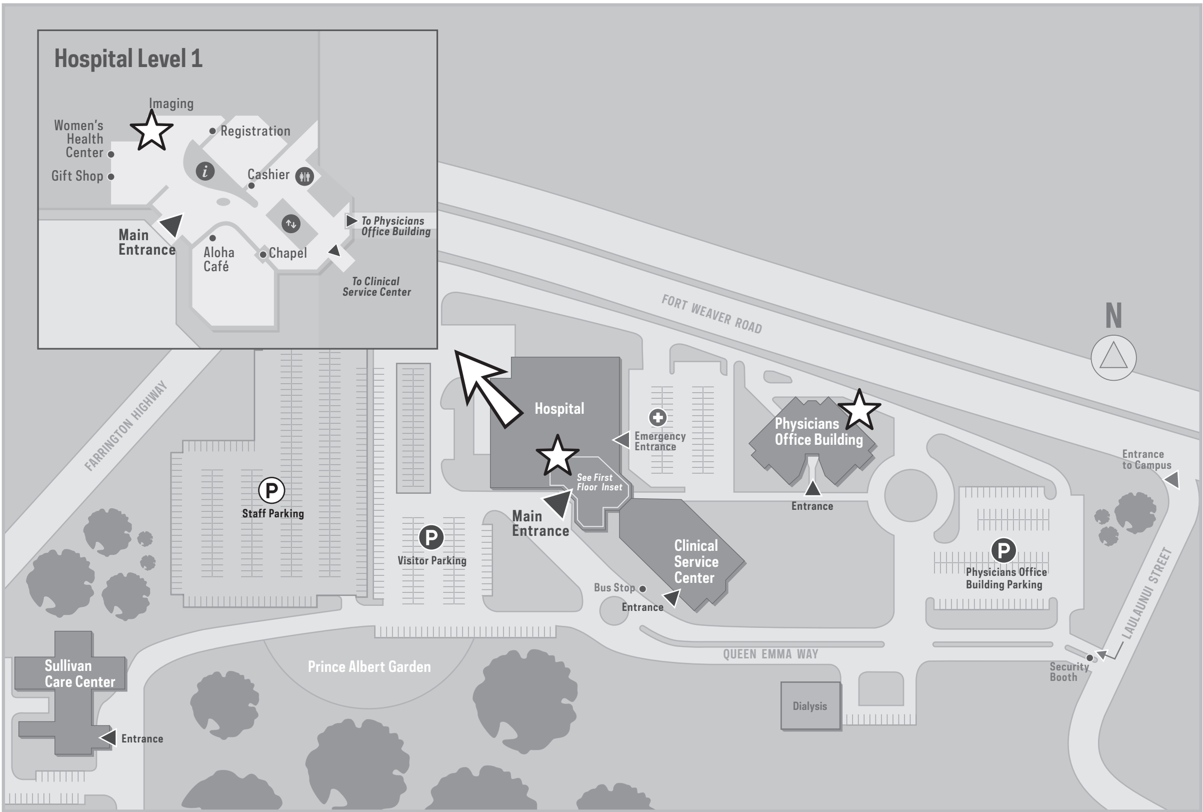


The Queen's Medical Center – Punchbowl

☆ **Physicians Office Building (POB) 2 – Basement Level**

☆ **Hospital – Level 1**

☆ **Physicians Office Building (POB) 3 – Basement Level**



The Queen's Medical Center – West O'ahu

☆ **Hospital – Level 1**

☆ **Physician's Office Building (POB) West O'ahu – Level 1, Suite 108**