

PET/CT REQUEST

Please call to schedule at 903-510-8778 or Fax information to 903-510-8806.

SECTION I - Must include the following with a PET/CT Request Form:

- Copy of front & back of patient's insurance card
 - Send all related radiology films with patient
 - All related radiology & Lab work results
- (If not available at the time of the scan, interpretation MAY be delayed.)

Please inform us if your patient is on oxygen, diabetic, disabled, claustrophobic, or needs other assistance.

SECTION II Facility Name / Location		Physician
Patient SS#		Physician Phone #
Patient Name		Physician Fax #
Date of Birth	Gender (M/F)	Primary Insurance (Include copy of insurance card)
Home Phone #		Primary Insurance Phone #
Work/Other Phone #		Pre-Certification/Authorization #
Best Time to Contact	Requested Scan Date	Secondary Insurance (Include copy of insurance card)
Diabetic Yes No	Weight/Height	Secondary Insurance Phone #

SECTION III - one of the following boxes must be checked to complete this request.

PET/CT Scan Codes		Brain/Heart PET/CT Scan Codes	
<input type="checkbox"/> Standard Body Study (<i>Skull Base-Mid Thigh</i>)	78815	<input type="checkbox"/> Myocardial Imaging, metabolic evaluation*	78459
<input type="checkbox"/> Whole Body Evaluation Imaging (<i>Skull Vertex to Toes</i>)	78816	<input type="checkbox"/> Brain Metabolic Imaging, metabolic evaluation*	78608
<input checked="" type="checkbox"/> Radiopharmaceutical (FDG)	A9552	* <i>Skip to Section V</i>	

SECTION IV - one of the following must be checked to complete this request.

Type of Cancer _____ **Histologically Proven** **Suspected**

Indications

Solitary Pulmonary Nodule	<input type="checkbox"/>	Diagnosis; Lymphoma	<input type="checkbox"/>
Diagnosis; Lung CA, NSC	<input type="checkbox"/>	Staging; Lymphoma	<input type="checkbox"/>
Staging; Lung CA, NSC	<input type="checkbox"/>	Restaging; Lymphoma	<input type="checkbox"/>
Restaging; Lung CA, NSC	<input type="checkbox"/>	Diagnosis; Head/Neck CA; excluding thyroid & CNS CA	<input type="checkbox"/>
Diagnosis; Colorectal CA	<input type="checkbox"/>	Staging; Head/Neck CA; excluding thyroid & CNS CA	<input type="checkbox"/>
Staging; Colorectal CA	<input type="checkbox"/>	Restaging; Head/Neck CA; excluding thyroid & CNS CA	<input type="checkbox"/>
Restaging; Colorectal CA	<input type="checkbox"/>	Diagnosis; Esophageal CA	<input type="checkbox"/>
Diagnosis; Melanoma	<input type="checkbox"/>	Staging; Esophageal CA	<input type="checkbox"/>
Staging; Melanoma	<input type="checkbox"/>	Restaging; Esophageal CA	<input type="checkbox"/>
Restaging; Melanoma	<input type="checkbox"/>	Staging; Breast CA	<input type="checkbox"/>
Restaging; Thyroid	<input type="checkbox"/>	Restaging; Breast CA	<input type="checkbox"/>
Staging; Cervical	<input type="checkbox"/>	Monitoring Tumor Response; Breast	<input type="checkbox"/>
<input type="checkbox"/> OTHER - All Other Cancers and All Other Indications:			
<input type="checkbox"/> NOPR:			

SECTION V - one of the following must be checked to complete this request.

Treatment

Has patient had treatment? YES NO

Type: Chemotherapy Date of Last Tx: _____ Radiotherapy Date of Last Tx: _____

Other: _____ Date of Last Tx: _____

Physician Signature	
Diagnosis	ICD-9 #
Reason for scan	

MUST SUPPLY FILMS/REPORTS FOR ALL STUDIES PREVIOUSLY PERFORMED FOR PRESENT CONDITION WITH THIS REQUEST.