

Please be advised that all questions must be answered completely.

<b>Patient name:</b>		<b>DOB:</b>	
<b>Insurance plan:</b>		<b>Member ID #:</b>	
Referring physician:	Dr.	Physician ID #:	
Physician address:		Specialty:	
City, state, zip:			
Physician fax #:		Physician phone #:	
Date of request:		Contact person:	
Imaging facility:	Name	Facility ID #:	
Facility address:			
City, state, zip:		Facility phone #:	
ICD-9 code/description			
Requested CPT code:		CPT code description:	
Date of last office visit (MM/DD/YYYY):	/	/	

Please circle the CPT or G code you are requesting:

78811	PET, limited	78816	PET with CT, whole body
78812	PET, skull base to mid thigh	78459	Myocardial imaging, PET, metabolic
78813	PET, whole body	78491	Myocardial imaging, PET, single study
78608	Brain imaging, PET metabolic evaluation	78492	Myocardial imaging, PET, multiple studies
78609	Brain imaging, PET perfusion evaluation	G0219	PET, whole body for melanoma
78814	PET with CT, limited	G0252	PET, breast cancer
78815	PET with CT, skull base to mid thigh	G0235	PET, unlisted

Cell type or tissue diagnosis and date of diagnosis:				Stage	
Reason for study: (circle one)	Initial staging	Restaging	Suspected recurrence	Surveillance	Evaluation for biopsy sit
Other rationale for this examination					
Prior imaging results (include type of examination and dates)					

Current tumor markers and date			
Most recent past tumor markers and date			
Liver function tests		Alkaline phosphatase	
Current symptoms			
Current findings on physical examination			

Currently on chemotherapy?      Yes \_\_\_\_\_      No \_\_\_\_\_

Completed chemotherapy?      Yes \_\_\_\_\_      No \_\_\_\_\_      Date \_\_\_\_\_

Currently on radiotherapy?      Yes \_\_\_\_\_      No \_\_\_\_\_

Completed radiotherapy?      Yes \_\_\_\_\_      No \_\_\_\_\_      Date \_\_\_\_\_

Surgery?      Yes \_\_\_\_\_      No \_\_\_\_\_      Date \_\_\_\_\_

If yes, please explain. \_\_\_\_\_  
 \_\_\_\_\_

Known metastatic disease:	Yes	No			
If yes, please check all that apply:	<input type="checkbox"/> Liver	<input type="checkbox"/> Lung	<input type="checkbox"/> Bone	<input type="checkbox"/> Brain	<input type="checkbox"/> Ovary
	<input type="checkbox"/> Pancreas	<input type="checkbox"/> Kidney	<input type="checkbox"/> Bowel	<input type="checkbox"/> Spine	<input type="checkbox"/> Spleen
Lymph nodes involved:	<input type="checkbox"/> Cervical	<input type="checkbox"/> Axillary	<input type="checkbox"/> Supraclavicular	<input type="checkbox"/> Hilar	<input type="checkbox"/> Mediastinal
	<input type="checkbox"/> Celiac	<input type="checkbox"/> Pelvic	<input type="checkbox"/> Porta Hepatis	<input type="checkbox"/> Iliac	<input type="checkbox"/> Inguinal
	<input type="checkbox"/> Retroperitoneal	<input type="checkbox"/> Other			

How will the results of this test influence patient management?			
Other pertinent information			

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Signature of requesting physician Date