

PET/CT Exam Order Form

Ordering Physician: _____ Order Date: _____

Patient Name: _____ SSN: _____

Pt Phone # _____ DOB: ___/___/___ M ___ F ___ Height: _____ Weight: _____

Diabetic? Yes ___ No ___ If yes, how controlled? _____

Date of Scheduled Exam: _____ Time: _____

DIAGNOSIS: _____ ICD-10 Code: _____

Select Requested Exam:

Reason for Scan:

____ Standard PET/CT (skull base to mid-thigh)

____ Initial Treatment Strategy

____ Whole Body PET/CT (DX: Melanoma only)

____ Subsequent Treatment Strategy (Restaging)

____ FDG Metabolic Brain Evaluation

____ Dementia

____ Amyloid Brain for Alzheimer's

____ Dotatate Evaluation Neuroendocrine Tumors _____ NETSPOT _____ DetectNET

____ PSMA for Prostate Cancer _____ Illucix _____ Pylarify

____ Cerianna for evaluation of metastatic ER positive Breast Ca

Prior PET Scans Date: ___/___/___ Location: _____

Prior CT Scans Date: ___/___/___ Location: _____

Treatment History:

SURGERY: _____ **CHEMO:** _____ **XRT:** _____

IMMUNOTHERAPY: _____ **SOMATOSTATIN FOR NEUROENDOCRINE:** _____

XGEVA, ZOMETA, RECLAST, GCSF: _____ (Should be off >3 wks to evaluate skeletal lesions)

Patient Insurance Company: _____

Policy Number: _____ Pre-Authorization Number: _____

Physician Signature: _____