

P.E.T./CT SCHEDULING REQUEST FORM

Please call 1-877-MRPETCT for scheduling and fax completed request form to (724) 883-3300

Appointment Date: _____ Appointment Time: _____

Patient Name: _____ DOB: _____ Age: _____ Sex: M/F

Address: _____

Home Phone: _____ S.S.#: _____ - _____ - _____ Wt: _____ <350 lbs.

Primary Care Physician: _____ Phone: _____ Fax: _____

Report to be sent to: _____

Is Patient Diabetic? YES NO

Diagnosis ICD-9 Code(s): _____

Primary Ins. Name: _____ Secondary Ins. Name: _____

Policy/ID# _____ Policy/ID# _____

Group # _____ Group/ID# _____

Pre-Cert/Auth # _____

Type of PET/CT scan requested: Please circle both the type of scan & reason for exam

	<u>Diagnosis</u>	<u>Initial Staging</u>	<u>Restaging</u>
Breast	G0254 (evaluation)	G0253/78810	G0253/78810
Colorectal	G0213/78810	G0214/78810	G0215/78810
Esophageal	G0226/78810	G0227/78810	G0228/78810
Head/Neck	G0223/78810	G0224/78810	G0225/78810
Lymphoma	G0220/78810	G0221/78810	G0222/78810
Melanoma	G0216/78810	G0217/78810	G0218/78810
NSCLC	G0210/78810	G0211/78810	G0212/78810
Brain Metabolic/Pre Surg/Epilepsy Eval		G0229/78608	
Brian Perfusion	78609		
Solitary Pulmonary Nodule		G0125/78810	
Whole Body PET other _____			
Thyroid			G0296/78810
CT Scan Diagnostic _____			

Please fax the following information with the scheduling request form:

- ° Recent imaging reports (CT, MRI, CXR, previous PET)
- ° Pathology/Biopsy/ Surgical Reports/Tumor Marker Values
- ° Recent films will need to be brought by the patient to the scan
- ° Recent history and physical or most recent progress note

Referring Physician (Printed): _____

Referring Physician Signature: _____ Date: _____