

### PET Scan Request Form

Phone: (603) 650-5560

Fax: (603) 650-6353

Date of procedure: \_\_\_\_\_ Time: \_\_\_\_\_ Nursing

\_\_\_\_\_ Injection

MUST CHOOSE ONE

\_\_\_\_\_ Scan

Patient name: \_\_\_\_\_

MRN: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's phone #: \_\_\_\_\_

Requesting physician: \_\_\_\_\_

Physician's phone #: \_\_\_\_\_

Initial treatment

Subsequent treatment (formally restaging and monitoring response to treatment)

Male

Female

If patient is female and of child bearing age (13-50):

Is there a possibility of pregnancy?  Yes  No

Is the patient breastfeeding?  Yes  No

**\*\*** For all oncology patients aged 18-40, an oral Xanax dose of 0.5mg will be administered by a radiology nurse 1 hour prior to the PET scan. This is to minimize muscle and brown fat activity seen on the PET scan. A driver must accompany the patient and remain through all appointments.

Please check here if you do NOT want your patient to receive Xanax mg orally 1 hour prior to the PET scan.

Indication for study: Please give a description of the disease and the reason for this test. Include details (e.g., of breast cancer, which breast?) and history of prior surgery for this disease: \_\_\_\_\_

Please specify which type of PET is requested:

Standard (includes neck, chest, abdomen, and pelvis) (78815)

Standard plus head and neck (for head/neck cancer) (78815)

Entire body, head to toes (for melanoma or where clinical concern is in extremities) (78816)

Brain only (dementia, seizures, brain tumor) (78608)

Cardiac viability (78459)

Cardiac perfusion (single 78491)

Cardiac perfusion (multiple 78492)

Approved by: \_\_\_\_\_

Additional instructions for technologist: \_\_\_\_\_

Has this study been pre-certified  Yes  No Pre-cert # \_\_\_\_\_ Exp. \_\_\_\_\_ CPT Code \_\_\_\_\_

Name of insurance plan: \_\_\_\_\_ Insurance representative's name: \_\_\_\_\_

Has this patient had a prior PET scan  Yes  No If yes, which facility: \_\_\_\_\_

Specifically related to this disease process, has this patient had:

Any prior x-rays  Yes  No If yes, which facility: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Any prior CTs  Yes  No If yes, which facility: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Any prior MRIs  Yes  No If yes, which facility: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

If patient has outside films, they:  Hand carry  Were sent  Are here

Does patient have any allergies  Yes  No If yes, please list: \_\_\_\_\_

Is there a problem with claustrophobia  Yes  No

Is this patient a diabetic  Yes  No Insulin? \_\_\_\_\_ Oral medication \_\_\_\_\_

Patient's height: \_\_\_\_\_ Patient's weight: \_\_\_\_\_

Scheduled by: \_\_\_\_\_ Date: \_\_\_\_\_