Dartmouth-Hitchcock MEDICAL CENTER

☐ Lebanon ☐ Lancaster

PET Scan Request Form

Phone: (603) 650-5560
Fax: (603) 650-6353

Date of procedure: _____ Time: _____Nursing
_____Injection
MUST CHOOSE ONE _____Scan

☐ Initial treatment
☐ Subsequent treatment (formally restaging and monitoring response to treatment)

Patient name: _____

MRN: _____ DOB: _____

Patient's phone #: _____

Requesting physician: _____

Physician's phone #: _____

☐ 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)
Approved by: _____
☐ Brain only (dementia, seizures, brain tumor) (78608)
☐ Cardiac viability (78459)
☐ Cardiac perfusion (single 78491)
☐ Cardiac perfusion (multiple78492)

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: _____