McLaren
GREATER LANSING

Submit

PET/CT Order Form *(please complete both pages)*

First available appointment will be given unless otherwise specified. _____

Patient Demographics

Patient Name: _____

Home Phone: _____ Secondary Phone: _____

Date of Birth: _____ ☐ Male ☐ Female Weight (Limit 400 lbs): Height: _____

Diabetic: ☐ Yes ☐ No ☐ Insulin ☐ Oral ☐ Diet

Previous Radiation: ☐ Yes ☐ No If yes, date of last treatment: _____ Body Area: _____

Previous Chemo: ☐ Yes ☐ No If yes, date of last treatment: _____

Has the patient had a previous PET scan for same cancer indication: ☐ Yes ☐ No

Insurance Information

Primary Insurance: _____

Secondary Insurance: _____

Pre-Authorization Required: ☐ Yes ☐ No

Pre-Authorization Number: _____

Diagnosis Code (required): _____

To help determine medical necessity, please fax the following documents:

- ☐ Most recent H & P
- ☐ Most recent progress notes
- ☐ Outside pathology report(s)
- ☐ Outside radiology report(s)
- ☐ Patient demographics

Reason for PET/CT Exam

ONCOLOGY

☐ Standard Body (78815) (routine use)
- ☐ *Initial Treatment Strategy (PI)*
- ☐ *Subsequent Treatment Strategy (PS)*
  (Restaging or Treatment Monitoring)

☐ Whole Body (78816) (melanoma or cancer below knee)
- ☐ *Initial Treatment Strategy (PI)*
- ☐ *Subsequent Treatment Strategy (PS)*
  (Restaging or Treatment Monitoring)

☐ Standard Body with Brain (78815)
(known or suspected brain mets)
- ☐ *Initial Treatment Strategy (PI)*
- ☐ *Subsequent Treatment Strategy (PS)*
  (Restaging or Treatment Monitoring)

BRAIN

☐ Alzheimer's vs Frontal Temporal Dementia (78608)
☐ Epilepsy for Surgical Evaluation
☐ Tumor Evaluation (78608)
(reoccurance vs Radiation Necrosis)

CARDIAC

☐ Myocardial Viability (78459)
(to include oral dextrose and IV insulin)
☐ Baseline Nuclear Perfusion (78451)
(to be ORDERED with myocardial viability)

NaF BONE SCAN

☐ Whole Body Bone Scan CPT (78816)

Ordering Physician Signature: _____ Date: _____ Time: _____

Via (Office Staff): _____

Corresponding visit ID Number: _____

The above named ordering physician hereby authorizes this electronic signature for this exam as evidenced by their physical signature contained in the above referenced visit ID number.

The above named ordering physician understands all forms sent containing PHI must be encrypted and the burden of encryption falls on the sender.

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Please complete both pages

CT:

☐ Yes ☐ No Has the patient had barium in the last five days?

☐ Yes ☐ No Does the patient have an iodine allergy

☐ Yes ☐ No Does the patient have a previous exam related to this study?
(If yes, please instruct the patient to bring them at the time of this study so as not to delay the results.)

☐ Yes ☐ No History of cancer?

☐ Yes ☐ No Is the patient diabetic?
(If "Yes": If requested exam requires iodinated contrast injection and patient takes diabetes medication containing Metformin, please contact Radiology or Central Scheduling for further instructions.)

☐ Yes ☐ No History of kidney impairment, disease, failure?

☐ Yes ☐ No Is the patient in renal failure?

☐ Yes ☐ No Is the patient pregnant or breast feeding?

_____ Patient weight

_____ Patient height

☐ Yes ☐ No Does the patient have special needs? *(If yes, please explain)*

_____

_____

☐ With ☐ Without Is the test being ordered with or without contrast?
☐ With and Without

If exam requires IV contrast, GFR screening may be required.
Consult Central Scheduling for conditions which may require lab work prior to exam.

If exam requires oral contrast, please arrive 2 hours prior to exam..