

PATIENT INFORMATION

[1] Patient Name _____	[2] Date of Birth _____	[3] Height _____	[4] Weight _____
[5] Patient Address _____	[6] Patient Telephone # _____	[7] Patient Mobile # _____	
[8] Referring Provider _____	[9] Provider Telephone # _____	[10] Provider Fax# _____	

[12] SIGNS AND SYMPTOMS (REQUIRED)

Type of cancer _____
 Histologically Proven Suspected
Please check Radiopharmaceutical
 FDG

CPT Codes _____
 If provided a specific CPT code, please provide.

INSURANCE INFORMATION

[13] Primary Insurance _____	[14] Subscribers Insurance ID # _____
Secondary Insurance _____	Insurance Prior Authorization # _____

CMS/APPROPRIATE USE CRITERIA (FOR MEDICARE PART B PATIENTS ONLY)

NPI# _____	Name of CDSM Consulted (software used) _____	Determination Result (check one): <input type="checkbox"/> 1) Adheres to <input type="checkbox"/> 2) Does Not Adhere to <input type="checkbox"/> 3) Not Applicable
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[15] (Check ONE and fill out corresponding section completely)

Initial Treatment Strategy

Diagnosis: Abnormal finding of _____
 Based on _____
Check one
 To determine whether the patient is a candidate for an invasive diagnosis or therapeutic procedure;
 To determine the optimal anatomic location for an invasive procedure; or
 To determine the anatomic extent of the tumor when the treatment recommendations depend on the extent,

Initial Staging: of confirmed newly diagnosed cancer
Check one
 To determine whether the patient is a candidate for an invasive diagnosis or therapeutic procedure;
 To determine the optimal anatomic location for an invasive procedure; or
 To determine the anatomic extent of the tumor when the treatment recommendations depend on the extent.

Other (e.g., Alzheimer's Disease). Please list reason for scan here:

Subsequent Treatment Strategy

Restaging: (after the completion of treatment)
Check one
 Status post the completion of treatment for the purpose of detecting residual disease
 Last date of treatment: _____
 Type of treatment: _____
 Detecting suspected recurrence, or metastasis of previously treated cancer:
 Site of suspected recurrence / metastasis: _____
 Based on: _____
 Determine the extent of a known recurrence.
 Confirmed by: _____
 PET/CT is being used to potentially replace one or more imaging studies that (1) is being utilized to determine extent of known recurrence of (2) provided insufficient information for the clinical management of the patient.

Monitoring Tumor Response: During Treatment
Check one
 Chemotherapy Radiotherapy Other (specify): _____

[16] PRESCREENING QUESTIONNAIRE

Prior Studies/Treatment

Pregnant: <input type="checkbox"/> Y <input type="checkbox"/> N	Previous: <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> PET/CT Where: _____	When: _____
Diabetes: <input type="checkbox"/> Y <input type="checkbox"/> N	Pathology: <input type="checkbox"/> Y <input type="checkbox"/> N Where: _____	When: _____
	Radiation Therapy: <input type="checkbox"/> Y <input type="checkbox"/> N Provider: _____	When: _____
	Chemotherapy: <input type="checkbox"/> Y <input type="checkbox"/> N Provider: _____	When: _____

[17] Authorized Treating Provider's Signature: _____	[18] NPI # _____	[19] Date _____
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Services provided by

Please FAX this form (and recent office notes, radiology reports and pathology reports) to Scheduling Department after patient's examination has been scheduled.