AFFILIATED P.E.T. SYSTEMS

PET/CT Referral Form

1400 Forest Glen Rd. Ste 430, Silver Spring, MD 20910

Scheduling: **301.681.9100** | Fax: **301.681.9141** | Tax ID: **52-2294497**

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 _____ _____ [10] Provider Telephone # _____ [11] Provider Fax# _____

[12] SIGNS AND SYMPTOMS (REQUIRED)

_____ ❑ Histologically Proven ❑ Suspected

Type of cancer

Please check Radiopharmaceutical

❑ **FDG** ❑ **Axumin**

❑ **Amyvid** ❑ **Cerianna**

❑ **Netspot** ❑ **Pylarify**

_____

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):

❑ 1) Adheres to ❑ 2) Does Not Adhere to ❑ 3) Not Applicable

[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

Pregnant: ❑ Y ❑ N

Diabetes: ❑ Y ❑ N

Prior Studies/Treatment

Previous:	❑ CT	❑ MRI	❑ PET/CT	Where: _____	When: _____
Pathology:	❑ Y	❑ N		Where: _____	When: _____
Radiation Therapy:	❑ Y	❑ N		Provider: _____	When: _____
Chemotherapy:	❑ Y	❑ N		Provider: _____	When: _____

_____ _____ _____

[17] **Authorized Treating Provider's Signature:** (Stamps Not Accepted) [18] **NPI #** [19] **Date**

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.