The Radiology Clinic

PET SCAN ORDER FORM

PATIENT LEGAL NAME:	**DATE OF BIRTH:**	**MALE** OR **FEMALE**		**SCHEDULED DATE AND TIME:**
TELEPHONE #:	**ALTERNATE PHONE #:**	**WEIGHT:**	**HEIGHT:**	**DIABETIC: Y** OR **N**
PRIMARY INSURANCE:	**POLICY:**			**PRECERT # (if needed):**

Required for Medical Verification: Physician office must fax H&P or Discharge Summary along with any lab, biopsy or Radiology reports to Radiology Scheduling - FAX: (205) 343-0935

Scan Type (check one) ☐ Skull Base to Mid-Thigh ☐ Whole Body for Melanoma and/or for known or suspected lower extremity tumors, sarcoma, multiple myeloma ☐ Brain Metabolic - (Differentiation between Alzheimer's & Fronto Temporal Dementia)	Initial Treatment Strategy (*formerly "diagnosis" and "staging"*) **Check appropriate indication**	Subsequent Treatment Strategy (*formerly "restaging" and "monitoring response to treatment"*) **Check appropriate indication**
Colorectal		
Esophagus		
Head and Neck (not Thyroid or CNS)		
Lymphoma		
Lung (Formerly SPN is Neoplasm of uncertain behavior of Respiratory System)		
Ovary		
Brain		
Cervix*		
Soft Tissue Sarcoma		
Pancreas		
Testes		
Prostate		
Breast (male and female) **		
Melanoma***		
All other solid tumors		
Myeloma		
Type of Cancer if not listed:		

Physician Signature: _____ **Date** _____ **Time** _____

PATIENT ID LABEL

Printed Physician's Name: _____

*Cervix: Non-covered for the initial diagnosis of cervical cancer related to initial anti-tumor treatment strategy. Covered for all other indications for initial anti-tumor treatment strategy.
**Breast: Non-covered for initial diagnosis and/or staging of axillary lymph nodes. Covered for initial staging of metastatic disease and all other indications for initial anti-tumor treatment strategy.
***Melanoma: Non-covered for initial staging of regional lymph nodes. Covered for all other indications for initial anti-tumor treatment strategy.