

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)				
<input type="checkbox"/> Skull Base to Mid-Thigh <input type="checkbox"/> Whole Body for Melanoma and/or for known or suspected lower extremity tumors, sarcoma, multiple myeloma <input type="checkbox"/> Brain Metabolic - (Differentiation between Alzheimer's & Fronto Temporal Dementia)	Initial Treatment Strategy <i>(formerly "diagnosis" and "staging")</i> Check appropriate indication		Subsequent Treatment Strategy <i>(formerly "restaging" and "monitoring response to treatment")</i> 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:				

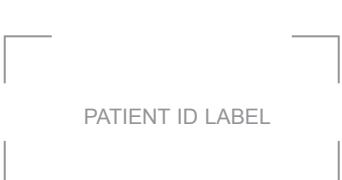
Physician Signature: _____ Date _____ Time _____

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.



PATIENT ID LABEL