

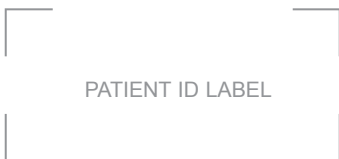
PET SCAN ORDER FORM

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	NOT COVERED	
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.