PET/CT Order Form

Phone: 313-576-9914 **Fax:** 313-576-9920
email: imagingpsr@karmanos.org
NPI: 1316900277 **Tax ID:** 201649466

CANCER INSTITUTE
Wayne State University

Instructions

Please fax this completed form with clinical information related to this exam to fax number **313-576-9920.**
First available appointment will be given unless otherwise specified: ____________________________

Patient Demographics

Name: ______________________________________
Primary Phone: ____________________ Secondary Phone: ____________________
Date of Birth: ________________ Male Female Weight: _______ Height: _______
Diabetic?: Yes No If yes, type of treatment: Insulin Oral Diet
Previous Radiation: Yes No If yes, Date of last treatment: ___________ Body Area: ______________
Previous Chemo:Yes No If yes, Date of last treatment: ___________
Has the patient had a previous PET scan for the same cancer indication: Yes No
Is the patient claustrophobic? Yes No

Insurance Information

Primary Insurance: _____________________________
Secondary Insurance: ____________________________
Pre-Authorization Required: Yes No
Pre-Authorization Number: _______________________
Diagnosis Code (Required): ______________________
Diagnosis: ___________________________________
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To help determine medical necessity please fax the following documents:

- Most recent H&P
- Most recent progress notes
- Outside Pathology report(s)
- Outside Radiology report(s)
- Patient demographics

REASON FOR PET/CT EXAM

ONCOLOGY

Standard Body **78815**
- Diagnostic
- Initial Treatment Strategy
- Subsequent Treatment Strategy

Whole Body **78816** (Melanoma, Multiple Myeloma or Osteosarcoma)
- Diagnostic
- Initial Treatment Strategy
- Subsequent Treatment Strategy

CARDIAC

Cardiac **78459**
- Myocardial Viability
- Sarcoidosis

BRAIN

18FDG Alzheimer’s vs Frontal Temporal Dementia **78608**
18FDG Epilepsy for Surgical Evaluation **78608**
18FDG Tumor Evaluation -Recurrence vs Radiation Necrosis **78608**

ADDITIONAL CLINICAL HISTORY

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REFERRING PHYSICIAN

Physician Signature: ____________________________ Printed Name: ____________________________

Office Phone: ______________________ Fax: ____________________

Contact Person: ____________________________ Date: ____________________

Physicians Address: ____