PET/CT Order Form

Phone: 313-576-9922 **Fax:** 313-576-9920
email: PETPSR@karmanos.org
NPI: 1316900277 **Tax ID**: 201649466

BARBARA ANN Karmanos 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: _____
_____

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

☐ Skull to Thigh **78815**
- ☐ Initial Treatment Strategy
- ☐ Subsequent Treatment Strategy

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

Prostate
- ☐ PSMA Ga-68

NET
- ☐ Dotatate

Research
Protocol/Study # _____
Tracer _____

CARDIAC

☐ Cardiac **78459***
- ☐ Myocardial Viability
- ☐ Sarcoidosis

* Includes resting myocardial perfusion study.

BRAIN

- ☐ 18FDG Alzheimer's vs Frontal Temporal Dementia **78608**
- ☐ 18FDG Epilepsy for Surgical Evaluation **78608**
- ☐ 18FDG Tumor Evaluation -Recurrence vs Radiation Necrosis **78608**
- ☐ 18F-Florbetapir (Amyvid) - Amyloid Brain PET/CT **78814**

ADDITIONAL CLINICAL HISTORY

_____
_____
_____

REFERRING PHYSICIAN

Physician Signature: _____ Printed Name: _____
Office Phone: _____ Fax: _____
Contact Person: _____ Date: _____
Physicians Address: _____