PET/CT REQUEST

Please call to schedule at 785-460-1205 or fax information to 460-9320

CITIZENS HEALTH

SHARED MEDICAL SERVICES

SECTION I - Must include the following with a PET/CT Request Form:

Copy of patient's insurance card (front & back)

All related radiology films or reports sent with patient

All related radiology, pathology and lab results

(If items are not available at the time of scan, interpretation MAY be delayed)

Please indicate if your patient is on oxygen, disabled, claustrophobic or needs other assistance.

SECTION II - All sections must be completed.		Physician
Scan Facility/Location		Physician NPI #
Requested Scan Date	Best Time to Contact	Physician Phone #
Patient SS#		Physician Fax #
Patient Name		Certification/Authorization #
DOB: MM/DD/YYYY	Gender: M F	Primary Insurance (Include copy of insurance card or demographics)
Home Phone #		Primary Insurance Phone #
Work/Other Phone #	Weight/Height	Secondary Insurance (Include copy of insurance card or demographics)

SECTION III - One of the following boxes must be checked to complete this request.

PET/CT FDG Scan Codes		
FDG - Standard Body Study (Skull Base-Mid Thigh)	◯ A9552 & 78815	
FDG - Brain Metabolic Imaging, Metabolic Evaluation	◯ A9552 & 78608	
FDG - Myocardial Imaging, Metabolic Evaluation	◯ A9552 & 78459	
FDG - Whole Body Evaluation Imaging (Skull Vertex-Toes)* *Typically used for melanoma and/or extremity/skull involvement	◯ A9552 & 78816	

*Cervix: Nationally non-covered for the initial diagnosis of cervical cancer related to initial anti-tumor treatment strategy. All other indications for initial anti-tumor treatment strategy for cervical cancer are nationally covered.
*Breast: Nationally non-covered for initial diagnosis and/or staging of axillary lymph nodes. Nationally covered for initial staging of metastatic disease. All other indications for initial anti-tumor treatment strategy for breast cancer are nationally covered.
*Melanoma: Nationally non-covered for initial staging of regional lymph nodes. All other indications for initial anti-tumor treatment strategy for melanoma are nationally covered.

SECTION IV

Type of Cancer: _____ ◯ **Histologically Proven** ◯ **Suspected**

Diagnosis Code: _____ ◯ **Subsequent** ◯ **Initial**

Must supply films/reports for all studies previously performed for present condition with this request.

SECTION V - History: This section must be filled out to complete this request.

Is the patient diabetic? ◯ YES ◯ NO If yes, how is it controlled? ◯ Diet ◯ Oral Meds ◯ Insulin

Has the patient had a PET/CT scan? ◯ YES ◯ NO Number of scans: _____ Date(s): _____

Has the patient had treatment? ◯ YES ◯ NO

Type: ◯ Chemotherapy Date of last Tx: _____ ◯ Radiotherapy Date of last Tx: _____

◯ Other: Date of last Tx: _____

Has the patient had surgery related to this diagnosis? ◯ YES ◯ NO Date(s): _____

Physician Signature	
Diagnosis	ICD-10 #
Reason for Scan	
Please Send Additional Copies of this Form to:	

MUST SUPPLY FILMS/REPORTS FOR ALL STUDIES PREVIOUSLY PERFORMED FOR PRESENT CONDITION WITH THIS REQUEST.