

Patient Name _____

MR # _____



PET/CT ORDER-MEDICAL NECESSITY FORM

EXAM REQUESTED: (check one)

PET/CT IS BEING REQUESTED TO: (check one)

<input type="checkbox"/>	Routine PET/CT – (skull base to mid thigh)
<input type="checkbox"/>	Whole Body PET/CT (skull base to feet-Melanoma)
<input type="checkbox"/>	Brain Only PET/CT
<input type="checkbox"/>	Chest Only (solitary pulmonary nodule)
<input type="checkbox"/>	Head and Neck only (top of head to mid chest)

Diagnose: before tissue confirmation

Stage: after diagnosis, but before treatment

Restage: after treatment course is finished

DIAGNOSIS: (check one)

<input type="checkbox"/>	Non-Small Cell Lung CA
<input type="checkbox"/>	Colorectal Cancer
<input type="checkbox"/>	Melanoma
<input type="checkbox"/>	Lymphoma
<input type="checkbox"/>	Lymphoma-Cutaneous
<input type="checkbox"/>	Head & Neck Cancer (excluding CNS, Thyroid)
<input type="checkbox"/>	Solitary Pulmonary Nodule (1 to 4 cm)
<input type="checkbox"/>	Breast (restaging)
<input type="checkbox"/>	Thyroid (restaging)
<input type="checkbox"/>	Esophageal

Pertinent x-ray information required:

CT ___/___/___ MR ___/___/___ PET ___/___/___ OTHER ___/___/___

Other clinical question to be answered by this study

Please note specific area of interest _____

Most recent chemo completed

Most recent RT completed

Patient diabetic? ___ Yes ___ No

Height _____ **Weight** _____

DECLARATION OF NECESSITY

I, _____, attest to the accuracy (Print Physician's Name) of the above information and the medical necessity of the study ordered.

Physician Signature _____

Date _____ **Beeper/ext.** _____

NOT APPROVED BY MEDICARE:

<input type="checkbox"/>	Sarcoma
<input type="checkbox"/>	Radiation necrosis vs. Recurrent brain tumor
<input type="checkbox"/>	Unknown diagnosis
<input type="checkbox"/>	Other diagnosis

PLEASE FAX TO 215-728-4755 OR CALL 215-214-4210 FOR ASSISTANCE.