PET SCHEDULING
877-877-8455
or 781-278-4304

PET FAX
866-927-0079
or 781-278-4309

# PET IMAGING

## Check Location

❑ Brighton - Steward St. Elizabeth's Medical Center
❑ Brockton - Steward Good Samaritan Medical Center
❑ Dorchester - Steward Carney Hospital
❑ Fall River - Saint Anne's Hospital
❑ Foxboro - Steward Foxboro
❑ Holyoke - Holyoke Medical Center
❑ Milton - Milton Hospital
❑ North Dartmouth - Hawthorn Medical Associates
❑ Northampton - Cooley Dickinson Hospital
❑ Westfield - Noble Hospital

## Patient Information

Interpreter needed? ❑ Yes ❑ No Language _____ MR#: _____

| [1.] Patient Name (please print) | | | | [2.] Patient Telephone # | [3.] Alternate Phone # |
|---|---|---|---|---|---|
| Last First | | | | | |
| [4.] Patient Address (Street, City and ZIP) | | | | | |
| | | | | | |
| [5.] Patient Sex | [6.] Date of Birth | [7.] Height | [8.] Weight | [9.] Pregnant | [10.] Diabetic |
| ❑ M ❑ F | | | | ❑ Yes ❑ No LMP date: | ❑ Yes ❑ No ❑ Insulin ❑ Pills |
| [11.] Practice Name (please print) | | | | [12.] Practice Telephone # | [13.] Practice Fax # |
| | | | | | |
| [14.] Ordering Physician Name (please print) | | | | [15.] Ordering Contact Name (please print) | |
| Last First | | | | | |
| [16.] Practice Address (Street, City and ZIP) | | | | | |
| | | | | | |
| [17.] Name of Insurance Co. | [18.] Insurance Co. Phone # | [19.] Subscribers Insurance ID | | [20.] Insurance Prior Author. # | |
| | | | | | |
| [21.] Secondary Insurance Co. | [22.] Insurance Co. Phone # | [23.] Subscribers Insurance ID | | [24.] Insurance Prior Author. # | |
| | | | | | |

*****Physician's Signature _____ Date: _____

## Clinical History

Choose one:
❑ Standard PET/CT (skull base to mid thigh, CPT 78815)
❑ Whole Body PET/CT (for Melanoma and NaF Bone, CPT 78816)
❑ Brain PET/CT (CPT 78608)

Choose one:
❑ Diagnosis
❑ Staging - Send Pathology Report
❑ Re-Staging
❑ Response to Therapy

[1.] Diagnosis

[2.] Indication

| [3.] Why is PET Scan being performed? | [4.] How Soon Needed? | [5.] STAT REPORT |
|---|---|---|
| | | ❑ Yes ❑ No |

[6.] Previous Please Fax Reports ❑ CT ❑ MRI ❑ PET

Where: When:

***Do not write below this line - office use only***

AM BS:_____ Exam Type: _____ Insurance Verified ❑ Account # _____

Scheduled/Prepped ❑ Outside Films ❑ Pre-registered ❑ Called MD with Appointment Date ❑ # of Oral Contrast Bottles _____

Dorse: _____ mCi FDG Time Administered: _____ Injection Site: _____ BS: _____ Initials: _____

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