

## Physician Information

Ordering Physician \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Physician(s) to be copied \_\_\_\_\_

cc Physician(s) fax \_\_\_\_\_

**Instructions** In order to process your request for a PET/CT scan, please fax this form and:

**Any reports from recent CT scans, MRIs, pathology, x-rays, chemotherapy, etc.**

## Patient Information

Patient Name \_\_\_\_\_ Phone \_\_\_\_\_

Patient has had a previous PET scan:  Yes  No

## PET/CT Scan (please check only ONE scan and ONE reason)

Exam	ICD-9 Code (see back of form)	Reason
<input type="checkbox"/> Breast	_____ (174.0 - 174.9)	<input type="checkbox"/> Staging <input type="checkbox"/> Restaging
<input type="checkbox"/> Colon (rectum, anus)	_____ (153.0 - 154.9)	<input type="checkbox"/> Staging <input type="checkbox"/> Restaging
<input type="checkbox"/> Cervical	_____ (180)	<input type="checkbox"/> Staging <input type="checkbox"/> Restaging
<input type="checkbox"/> Esophageal	_____ (150.0 - 150.9)	<input type="checkbox"/> Diagnosis <input type="checkbox"/> Staging <input type="checkbox"/> Restaging
<input type="checkbox"/> Head/Neck (lip, oral cavity, pharynx, nasal cavity, ear, sinuses, larynx)	_____ (see back of form)	<input type="checkbox"/> Diagnosis <input type="checkbox"/> Staging <input type="checkbox"/> Restaging
<input type="checkbox"/> Lung Cancer (non small cell, lung mass)	_____ (162.0 - 162.9)	<input type="checkbox"/> Diagnosis <input type="checkbox"/> Staging <input type="checkbox"/> Restaging
<input type="checkbox"/> Lung Masses	_____ (162.0)	<input type="checkbox"/> Diagnosis
<input type="checkbox"/> Solitary Pulmonary Nodule (SPN) single nodule <4 cm	_____ (235.7)	<input type="checkbox"/> Diagnosis
<input type="checkbox"/> Lymphoma	_____ (200.0 - 202.8)	<input type="checkbox"/> Diagnosis <input type="checkbox"/> Staging <input type="checkbox"/> Restaging
<input type="checkbox"/> Melanoma	_____ (172.0 - 172.9)	<input type="checkbox"/> Diagnosis <input type="checkbox"/> Staging <input type="checkbox"/> Restaging
<input type="checkbox"/> Thyroid	_____ (193.0)	<input type="checkbox"/> Staging <input type="checkbox"/> Restaging
<input type="checkbox"/> Differentiate between FTD and Alzheimer's	_____ (331.0)	<input type="checkbox"/> Diagnosis

## Diagnostic CT (CT Prerequisite: Labs Creatinine and BUN within 3 months)

- |                                     |   |                                      |
|-------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Head/Brain | <input type="checkbox"/> Chest          | <input type="checkbox"/> Sinus       |
| <input type="checkbox"/> Neck       | <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> CTA         |
| <input type="checkbox"/> Abdomen    | <input type="checkbox"/> Thoracic Spine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Pelvis     | <input type="checkbox"/> Lumbar Spine   |                                      |

**No Contrast**

Does the patient have allergies to:  Iodine  Shellfish  Other \_\_\_\_\_

Diabetic patients on Metformin/Glucophage:  Doctor approved 48 hrs off medication after exam

**If the patient is pregnant or nursing, please notify staff**

Additional Notes \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

***ologic PET Registry.***

174.0 - 174.9      breast

**HMSA 65 C+** follows Medicare guidelines - The National Oncologic PET Registry does not apply

Other Insurance companies that **DO NOT** require prior authorization: **HMAA, Hawaii Laborers Health & Welfare**

Insurance companies that **DO** require prior authorization for all PET/CT scans: **Medicaid, Aloha Care, United Health Care, University Health Alliance, TriCare For Life, TriWest**

To better serve you, precertification can be facilitated by Hawaii Advanced Imaging Institute