



NORTH FLORIDA
7000 NW 11th Place ■ Gainesville, Florida 32605
(352) 331-0900 ■ Fax (352) 331-1511

LAKE-CITY
4520 West US Hwy 90 ■ Lake City, Florida 32055
(386) 755-0601 ■ Fax (386) 755-0602

PET/CT SCAN REQUEST FORM

Patient Name:		DOB: / /	
Home:	Work:	Mobile:	
ICD-9 Code(s):			
Social Security Number:			
Ordering Physician:	Phone:	Fax:	
Follow-up Appointment Date:			

Order: Integrated PET/CT scan utilizing a non-contrast diagnostic CT

<input type="checkbox"/> Standard Body (eyes to thighs protocol)	78815	<input type="checkbox"/> Brain (primary brain tumor protocol)	78608
<input type="checkbox"/> Whole Body (head to toe protocol)	78816	<input type="checkbox"/> Dementia	78608
<input type="checkbox"/> Standard Body with Brain (for known or suspected brain mets)	78815	<input type="checkbox"/> Characterization of a Solitary Pulmonary Nodule	78815
		<input type="checkbox"/> Limited Study (physician defined protocol)	78814

Reason for ordering a PET/CT scan:

<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Staging (pre-treatment)
<input type="checkbox"/> Restaging (post-treatment) <i>RE-STAGING: Using PET/CT after an entire course of therapy is completed to see if the treatment worked or if there is persistent disease. Re-staging should be used when a physician is trying to identify a recurrence.</i>	<input type="checkbox"/> Treatment Monitoring/Treatment Assessment <i>TREATMENT ASSESSMENT: Using PET/CT to scan a patient during a planned course of chemotherapy or radiation therapy to see if the therapy is working and determine if the patient should continue on the same course of therapy.</i>
	<input type="checkbox"/> Radiation Therapy Treatment Planning

Questions:

Is patient currently undergoing a planned course of therapy? Y N Chemotherapy Radiation Therapy

When is the patient's next treatment? _____ N/A

Please attach the following:

- Clinical/Office/Surgical Notes
- Pathology Report
- Labs
- Patient Demographic Data
- Copy of Insurance Card
- Imagery Reports - please mark below which one(s) are attached

Bone Scan Chest X-ray MRI CT PET/CT (Previous Date _____) Other

Physician Signature _____

Date _____



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CT SCAN REQUEST FORM

Patient Name:		DOB: / /	M F (circle one)
Home:	Work:	Mobile:	
ICD-9 Code(s):		Diagnosis:	
Patient Address:	City:	Zip:	
Ordering Physician:	Phone:	Fax:	
Follow-up Appointment Date:			

Order: Diagnostic CT

70450	CT head or brain w/o	72130	CT thoracic spine w & w/o
70460	CT head or brain w	72131	CT lumbar spine w/o
70470	CT head or brain w & w/o	72132	CT lumbar spine w
70480	CT orbit; sella; inner ear w/o	72133	CT lumbar spine w & w/o
70481	CT orbit; sella; inner ear w	72192	CT pelvis w/o
70482	CT orbit; sella; inner ear w & w/o	72193	CT pelvis w
70486	CT maxillofacial w/o	72194	CT pelvis w & w/o
70487	CT maxillofacial w	73200	CT upper extremity w/o
70488	CT maxillofacial w & w/o	73201	CT upper extremity w
70490	CT soft tissue neck w/o	73202	CT upper extremity w & w/o
70491	CT soft tissue neck w	73700	CT lower extremity w/o
70492	CT soft tissue neck w & w/o	73701	CT lower extremity w
71250	CT thorax w/o	73702	CT lower extremity w & w/o
71260	CT thorax w	74150	CT abdomen w/o
71270	CT thorax w & w/o	74160	CT abdomen w
72125	CT cervical spine w/o	74170	CT abdomen w & w/o
72126	CT cervical spine w	76370	CT for radiation therapy fields
72127	CT cervical spine w & w/o	76376	3D rendering w/o post process
72128	CT thoracic spine w/o	76377	3D rendering w/post process
72129	CT thoracic spine w	76380	CT limited or localized follow-up

Reason for Ordering a Diagnostic CT Scan:

Physician Signature

Date