

PET IMAGING

TO SCHEDULE AN APPOINTMENT PLEASE CALL 888-353-4808

DALLAS

8333 Douglas Avenue ■ Suite C-20 ■ Dallas, Texas 75225
(214) 373-4200 ■ Fax (214) 373-4204

DALLAS-NORTHEAST

1250 R. Northwest Highway ■ Garland, Texas 75041
(972) 279-5172 ■ Fax (972) 279-6948

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
Has the patient had a previous PET/CT scan? Y N
What question(s) do you want the PET/CT scan to answer? _____

Physician Signature _____

Date _____

Please provide a copy of the patient demographic data along with a copy of their insurance.

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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

Please provide a copy of the patient demographic data along with a copy of their insurance.

VERSION 2 • 2-08 • PET/CT & DIAGNOSTIC CT REQUISITION