Rutland Regional Medical Center

PET/CT ORDER FORM

Fax to Central Scheduling: 802.776.3301

Central Scheduling: 802-747-1880

PATIENT INFORMATION: ***(Note: 48 hours required for appointment cancellations, 747-1880)***

Patient Name: ______________________________ Medical Record Number: __________________

Best Daytime Phone: ______________________________ ☐ Male ☐ Female DOB:__________________

Insurance Co: ______________________ Policy #: ______________ Ins Auth #: ______________

Indication for the study. Please give a description of the disease and the reason for this test. Include details (e.g. if breast cancer, which breast) and history of prior surgery for this disease.

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Has this patient had a prior PET scan? ☐Yes ☐No If yes, which facility? ______________________

Specifically related to this disease process, has this patient had:

A prior x-ray? ☐ Yes ☐ No What facility?______________________ Date:____________

A prior CT? ☐ Yes ☐ No What facility?______________________ Date:____________

A prior MRI? ☐ Yes ☐ No What facility?______________________ Date:____________

Is patient diabetic? Y / N Insulin dependent? Y / N Possibility of pregnancy? Y / N Breastfeeding? Y / N

Does patient have allergies? (e.g. latex, meds) ☐Yes ☐No If yes, ______________________

Is there a problem with claustrophobia? ☐Yes ☐No If yes, what med was prescribed? ____________

What medications is patient taking? ____

____ **Pt's weight:** __________ lbs

PET/CT SCAN, CPT Code 78815: BASE OF SKULL TO MID-THIGH

Check one ► ☐ Diagnosis, Initial Staging (PI) ☐ Treatment Monitoring, Restaging, Suspected Recurrence (PS)

PET/CT SCAN, CPT Code 78816: WHOLE BODY (typically just for Melanoma)

NOTE: For cancers other than Melanoma, provide documentation; clinical circumstances must support 78816 vs 78815

Check one ► ☐ Diagnosis, Initial Staging (PI) ☐ Treatment Monitoring, Restaging, Suspected Recurrence (PS)

PET/CT SCAN, CPT Code 78608: BRAIN

Check one ► ☐ Diagnosis, Initial Staging (PI) ☐ Treatment Monitoring, Restaging, Suspected Recurrence (PS)

Requesting Physician: ______________________ Physician Signature: ______________________

Physician's Phone Number: ______________________ Physician's Fax Number: ______________________

Order Date: ________________ Time: __________

FOR CENTRAL SCHEDULING USE:

SCHEDULED BY: ____________ **APPOINTMENT DATE/TIME:** ______________________

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