

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 ca, which breast?) and history of prior surgery for this disease. \_\_\_\_\_

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What facility? _____	Date: _____
A prior CT?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What facility? _____	Date: _____
A prior MRI?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: \_\_\_\_\_

