



PET/CT Written Order Form F18- FDG Imaging

Cape Cod PET-CT Services, LLC

- Fontaine Medical Center Sandwich Health Center
 525 Long Pond Drive 2 Jan Sebastian Drive
 Harwich, MA 02645 Sandwich, MA 02563

To schedule PET/CT studies:
Call 1-866-258-4PET (4738)
 or
Fax form to 1-888-662-4700

Tax ID: 26-3892846

Patient's Name: _____ DOB: ____/____/____

Phone #: _____ SSN: ____-____-____

Diagnosis/ICD-9 Code: _____

Previous CT/MRI – Where: _____

REQUESTED PROCEDURE

Solitary Pulmonary Nodule <input type="checkbox"/> Characterization	Lung Cancer <input type="checkbox"/> Diagnosis <input type="checkbox"/> Staging <input type="checkbox"/> Restaging	Lymphoma <input type="checkbox"/> Diagnosis <input type="checkbox"/> Staging <input type="checkbox"/> Restaging	Colorectal Cancer <input type="checkbox"/> Diagnosis <input type="checkbox"/> Staging <input type="checkbox"/> Restaging
Esophageal Cancer <input type="checkbox"/> Diagnosis <input type="checkbox"/> Staging <input type="checkbox"/> Restaging	Head and Neck Cancer <input type="checkbox"/> Diagnosis <input type="checkbox"/> Staging <input type="checkbox"/> Restaging	Breast Cancer <input type="checkbox"/> Diagnosis <input type="checkbox"/> Staging <input type="checkbox"/> Restaging	Melanoma <input type="checkbox"/> Diagnosis <input type="checkbox"/> Staging <input type="checkbox"/> Restaging
Thyroid Cancer <input type="checkbox"/> Restaging	Myocardial Viability <input type="checkbox"/> Metabolic evaluation	Tumor Imaging <input type="checkbox"/> Tumor imaging Tumor type _____	Cervical Cancer <input type="checkbox"/> Staging
Brain Imaging <input type="checkbox"/> Evaluation of tumor recurrence <input type="checkbox"/> Refractory Seizures <input type="checkbox"/> Alzheimer's Disease	Immobilization Device <input type="checkbox"/> Head Cup <input type="checkbox"/> Mask	Arm Position <input type="checkbox"/> Arms Up <input type="checkbox"/> Arms Down	Other <input type="checkbox"/> 3mm slices <input type="checkbox"/> _____

Physician's Signature: _____ Phone #: _____

Physician's Name (please print): _____ Fax #: _____

Billing Information/Insurance Company: _____

Policy #: _____

Pre-Authorization #: _____

Appointment Date: _____ Time: _____ AM PM Location: _____

By signing this request form, I acknowledge full responsibility for the information that must be completed and maintained in this patient's medical record in my office. I have verified that all conditions described above have been met. Upon request I will make this documentation available to the provider and/or to CMS, its agents or other authorized personnel for review.

10/09

Please have patient bring any previous CT, MRI, PET films with them to their appointment.

