



PET

Positron Emission Tomography

PET/CT Written Order Form F18- FDG Imaging

UMass Memorial MRI & Imaging Center, PET Imaging Services
214 Shrewsbury Street
Worcester, MA 01604
Tax ID: 04-3454298

275 Nichols Road
Fitchburg, MA 01420
Tax ID: 04-3454298

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

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"/> Staging <input type="checkbox"/> Restaging during treatment	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			

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.

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