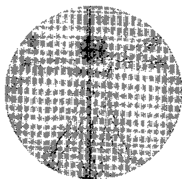

PET/CT Written Order Form F18- FDG Imaging

Baystate MRI & Imaging Center, PET Imaging Services
3300 Main Street
Springfield, MA 01107
Tax ID: 04-3454301

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	**Lung Cancer**	**Lymphoma**	**Colorectal Cancer**
☐ Characterization	☐ Diagnosis ☐ Staging ☐ Restaging	☐ Diagnosis ☐ Staging ☐ Restaging	☐ Diagnosis ☐ Staging ☐ Restaging
Esophageal Cancer ☐ Diagnosis ☐ Staging ☐ Restaging	**Head and Neck Cancer** ☐ Diagnosis ☐ Staging ☐ Restaging	**Breast Cancer** ☐ Staging ☐ Restaging during treatment	**Melanoma** ☐ Diagnosis ☐ Staging ☐ Restaging
Thyroid Cancer ☐ Restaging	**Myocardial Viability** ☐ Metabolic evaluation	**Tumor Imaging** ☐ Tumor imaging Tumor type ______	**Cervical Cancer** ☐ Staging
Brain Imaging ☐ Evaluation of tumor recurrence ☐ Refractory Seizures ☐ 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.