



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

Baystate MRI & Imaging Center

80 Wason Avenue
Springfield, MA 01107
Tax ID: 04-3454301

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"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment	Lymphoma <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment	Colorectal Cancer <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment
Esophageal Cancer <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment	Head and Neck Cancer <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment	Breast Cancer <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment	Melanoma <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment
Thyroid Cancer <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment	Cervical Cancer <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment	Myeloma <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment	Ovarian Cancer <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment
Brain Imaging <input type="checkbox"/> Evaluation of tumor recurrence <input type="checkbox"/> Refractory Seizures <input type="checkbox"/> Alzheimer's Disease	Tumor Imaging <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment Tumor type _____	Bone Imaging <input type="checkbox"/> 18F-FDG <input type="checkbox"/> 18F-Sodium Fluoride	Myocardial Imaging <input type="checkbox"/> Metabolic Evaluation
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 CT 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.

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