PET/CT Written Order Form F18- FDG Imaging

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

□ **UMass Memorial HealthAlliance**
MRI Center-Burbank Campus
275 Nichols Road
Fitchburg, MA 01420
Tax ID: 04-3454298

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

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	☐ Initial Treatment ☐ Subsequent Treatment	☐ Initial Treatment ☐ Subsequent Treatment	☐ Initial Treatment ☐ Subsequent Treatment
Esophageal Cancer ☐ Initial Treatment ☐ Subsequent Treatment	**Head and Neck Cancer** ☐ Initial Treatment ☐ Subsequent Treatment	**Breast Cancer** ☐ Initial Treatment ☐ Subsequent Treatment	**Melanoma** ☐ Initial Treatment ☐ Subsequent Treatment
Thyroid Cancer ☐ Initial Treatment ☐ Subsequent Treatment	**Cervical Cancer** ☐ Initial Treatment ☐ Subsequent Treatment	**Myeloma** ☐ Initial Treatment ☐ Subsequent Treatment	**Ovarian Cancer** ☐ Initial Treatment ☐ Subsequent Treatment
Brain Imaging ☐ Evaluation of tumor recurrence ☐ Refractory Seizures ☐ Alzheimer's Disease	**Tumor Imaging** ☐ Initial Treatment ☐ Subsequent Treatment Tumor type_________	**Bone Imaging** ☐ 18F-FDG ☐ 18F-Sodium Fluoride	**Myocardial Imaging** ☐ Metabolic Evaluation
Immobilization Device ☐ Head Cup ☐ Mask	**Arm Position** ☐ Arms Up ☐ Arms Down	**Other** ☐ 3mm CT slices ☐ ____________________	

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.

3/2010

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