RHODE ISLAND
PET Services, LLC

NPI#: **1538113113** | TAX ID#: **043-59-3126**

Kent Hospital

Scheduling: **866.245.5995** | Fax: **800.508.1064**

Cardiac PET/CT Referral Form

PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Height _____ Weight _____

Patient Address _____ Patient Telephone # _____ Patient Mobile # _____

Referring Provider _____ Provider Telephone # _____ Provider Fax# _____

SIGNS AND SYMPTOMS (REQUIRED)

❑ **78431** – Multiple PET perfusion studies (rest and stress) with concurrently acquired CT transmission scan, including ventricular wall motion and/or ejection fraction when performed.

❑ **78433** – Combined PET perfusion and metabolic evaluation study (dual radiotracer; e.g., myocardial viability) with concurrently acquired CT transmission scan.

Radiopharmaceutical: ❑ RB-82

INSURANCE INFORMATION

Primary Insurance _____ Subscribers Insurance ID # _____

Secondary Insurance _____ Insurance Prior Authorization **#** _____

REQUIRED INFORMATION FOR SCHEDULING *(Fax all information to scheduling at 800.508.1064)*

❑ Completed PET/CT request form

❑ Note CPT code and radiopharmaceutical desired for PET/CT scan

❑ Copies of ALL prior imaging reports

❑ Latest physician office note pertaining to PET/CT order

CLINICAL INDICATION *(check all that apply)*

❑ Myocardial perfusion evaluation

❑ Coronary artery disease evaluation

❑ Viability assessment

❑ Ischemia detection

❑ Other:_____

PRESCREENING QUESTIONNAIRE

Pregnant: ❑Y ❑N

Diabetes: ❑Y ❑N

Prior Studies/Treatment

Previous: ❑ CT ❑ MRI ❑ PET/CT Where:_____ When: _____

Pathology: ❑Y ❑N Where:_____ When: _____

Authorized Treating Provider's Signature: (Stamps Not Accepted) _____ **NPI #** _____ **Date** _____

AKUMIN®

Please FAX this form (and recent office notes, radiology reports and pathology reports) to our Scheduling Department Insurance verification/authorization can not be started without this information.