



R H O D E I S L A N D

PET Services, LLC

Roger Williams Medical Center  Kent Hospital  Landmark Medical Center

Scheduling: 866.245.5995 | Fax: 800.508.1064

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

# PET/CT Referral Form

## PATIENT INFORMATION

|                             |                               |                        |                           |
|-----------------------------|-------------------------------|------------------------|---------------------------|
| _____<br>Patient Name       | _____<br>Date of Birth        | _____<br>Height        | _____<br>Weight           |
| _____<br>Patient Address    | _____<br>Patient Telephone #  |                        | _____<br>Patient Mobile # |
| _____<br>Referring Provider | _____<br>Provider Telephone # | _____<br>Provider Fax# |                           |

## SIGNS AND SYMPTOMS (REQUIRED)

\_\_\_\_\_  
**Type of cancer**  Histologically Proven  Suspected

\_\_\_\_\_  
**CPT Codes** **Please check Radiopharmaceutical**

FDG  Amyvid  Neuraceq  Posluma  
 Cerianna  Illucix  Netspot  Pylarify

## 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  Pathology Report - pertaining to PET/CT order  Please make sure to include PSA value for PSMA prostate scans

*(Check ONE and fill out corresponding section completely)*

### Initial Treatment Strategy

- Diagnosis:** Abnormal finding of \_\_\_\_\_  
Based on \_\_\_\_\_
- Check one**
- To determine whether the patient is a candidate for an invasive diagnosis or therapeutic procedure;
- To determine the optimal anatomic location for an invasive procedure; or
- To determine the anatomic extent of the tumor when the treatment recommendations depend on the extent,
- Initial Staging:** of confirmed newly diagnosed cancer
- Check one**
- To determine whether the patient is a candidate for an invasive diagnosis or therapeutic procedure;
- To determine the optimal anatomic location for an invasive procedure; or
- To determine the anatomic extent of the tumor when the treatment recommendations depend on the extent.
- Other** (e.g., Alzheimer's Disease). Please list reason for scan here:  
\_\_\_\_\_

### Subsequent Treatment Strategy

- Restaging:** (after the completion of treatment)
- Check one**
- Status post the completion of treatment for the purpose of detecting residual disease  
Last date of treatment: \_\_\_\_\_  
Type of treatment: \_\_\_\_\_
- Detecting suspected recurrence, or metastasis of previously treated cancer:  
Site of suspected recurrence / metastasis: \_\_\_\_\_  
Based on: \_\_\_\_\_
- Determine the extent of a known recurrence.  
Confirmed by: \_\_\_\_\_
- PET/CT is being used to potentially replace one or more imaging studies that (1) is being utilized to determine extent of known recurrence of (2) provided insufficient information for the clinical management of the patient.
- Monitoring Tumor Response:** During Treatment
- Check one**
- Chemotherapy  Radiotherapy  Other (specify): \_\_\_\_\_

## PRESCREENING QUESTIONNAIRE

### Prior Studies/Treatment

|                                                                 |                                                                                                    |                 |             |
|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-----------------|-------------|
| Pregnant: <input type="checkbox"/> Y <input type="checkbox"/> N | Previous: <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> PET/CT | Where: _____    | When: _____ |
| Diabetes: <input type="checkbox"/> Y <input type="checkbox"/> N | Pathology: <input type="checkbox"/> Y <input type="checkbox"/> N                                   | Where: _____    | When: _____ |
|                                                                 | Radiation Therapy: <input type="checkbox"/> Y <input type="checkbox"/> N                           | Provider: _____ | When: _____ |
|                                                                 | Chemotherapy: <input type="checkbox"/> Y <input type="checkbox"/> N                                | Provider: _____ | When: _____ |

Authorized Treating Provider's Signature: (Stamps Not Accepted)

NPI #

Date



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.