



## Outpatient Order for PET Exam

**TO SCHEDULE PET EXAMS, CALL THE PET CENTER PH#: 404-778-4765 FAX#: 404-712-0296**

**Patient Information:**  
**Name** *(Last, First MI.):* \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**The staff must be informed if the Patient is Claustrophobic.** Yes  No   
 Male  Female  **Pregnant:** Yes  No  **Diabetic:** Yes  No  **Weight:** \_\_\_\_\_  
**Ordering Physician** \_\_\_\_\_ **UPIN#** \_\_\_\_\_  
**Phone #** \_\_\_\_\_ **Fax#** \_\_\_\_\_  
 Referral required for Radiology services? Yes  No  Referral Number \_\_\_\_\_  
*If pre-certification is required for a non-emergent exam, managed care plans require that the exam be scheduled at least 4 days in advance.*

**Exam & Clinical Information:** PET-CT is routine for body cases and at special request  
**Exam Requested:** check one  Body PET  Brain PET  Other  
 Requested Exam Date: \_\_\_\_\_  **Confirmed Exam Date** \_\_\_\_\_  
**Diagnosis/ICD-9 Code(s):** \_\_\_\_\_  
**Clinical Indications and Relevant Symptoms:** *check one each in History and Indication*  
**History:**  
 lung nodule  lung cancer  colorectal cancer  melanoma  lymphoma  esophageal  
 head&neck (not thyroid or CNS)  breast cancer  thyroid cancer  seizure  dementia  
 cervical cancer  other: \_\_\_\_\_  
**Indication:**  
 Diagnosis (includes avoiding or directing biopsy)  
 Initial Staging  
 Restaging and/or response  
 Other: \_\_\_\_\_ Enclosures Faxed:  Labs  Radiology Reports  Other \_\_\_\_\_  
**MEDICARE:**  
 Signed Medicare ABN attached *(Required if medical necessity does not meet Medicare criteria)*

**Referring Physician address:** \_\_\_\_\_  
**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_  
*(Original signature required for HCFA Compliance)*

**Patient's Home Ph#** \_\_\_\_\_ **Patient's Contact Ph#** \_\_\_\_\_  
**SS#** \_\_\_\_\_ **Address:** \_\_\_\_\_  
**Insurance Carrier** \_\_\_\_\_ **Ph#** \_\_\_\_\_ **ID#** \_\_\_\_\_  
**Policy Type:**  HMO  PPO  POS  Indemnity  Medicaid  GBHC  Medicare  
 Workers Comp.  Dental  Other \_\_\_\_\_  
*\* Please provide a copy of the front and back of Insurance Card.*

Form Completed by: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
**\*\* Please fax form back to Radiology/PET\*\*** **DATE FAXED** \_\_\_\_\_

Download Order Form at Intranet: [http://www.eushc.org/departments/ehcradiology/Nuclear\\_Medicine/index.html](http://www.eushc.org/departments/ehcradiology/Nuclear_Medicine/index.html)  
 or Internet: <http://www.emoryhealthcare.org/departments/Radiology/services/PET.html#forms>