SILVER CROSS HOSPITAL

The way you *should* be treated.™

1900 Silver Cross Blvd., New Lenox, IL 60451

PET/CT Scheduling: (815) 300-7076

PET/CT Fax: (815) 300-1063

(1.) Patient Name	*(2.) Date of Birth*	*(3.) Patient Telephone #*

(4.) Referring Physician	*(5.) Physician Telephone #*	*(6.) Physician Fax #*

(7.) Primary Insurance	*(8.) Subscriber's Insurance ID #*

Secondary Insurance	*Insurance Prior Authorization #*

(9.) Signs and Symptoms

Type of Cancer_____ ❑ Histologically Proven ❑ Suspected

CPT Codes: Please Check One

❑ 78815 PET/CT; skull base to mid-thigh ❑78816 PET/CT; whole body; skull to feet ❑ 78608 Brain imaging, PET/CT; metabolic evaluation

(10.) SPECIFIC REASON FOR PET/CT STUDY

Check one of the four reasons for PET/CT Study and completely fill out the corresponding section.

INITIAL TREATMENT STRATEGY

❑ **Diagnosis:** Abnormal finding of _____ based on _____

Check one

❍ To determine whether the patient is a candidate for an invasive diagnostic 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 diagnostic 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.

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 a previously treated cancer:

Site of suspected recurrence / metastasis: _____ based on: _____

(circle one)

❍ 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 or 2) provided insufficient information for the clinical management of the patient.

- Number of related restaging PET/CTs _____(Cllinical notes are required for Medicare patients with more than 3 related PET/CT's.)

❑ **Monitor Tumor Response:** During Treatment

Check one

❍ Chemotherapy ❍ Radiology ❍ Other (Specify): _____

(11.) Prescreening Questionaire

Pregnant: Y ❑ N ❑

Diabetes: Y ❑ N ❑

PRIOR STUDIES/TREATMENT

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

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

Radiation Therapy: Y ❑ N ❑ Physician: _____ When: _____

Chemotherapy: Y ❑ N ❑ Physician: _____ When: _____

(12.) Physician's or Authorized Treating Practitioner's Signature Only* (Stamps Not Accepted)	(13.) Date