

Patient Name _____ Date exam needed: _____

DOB _____ Gender _____ Weight _____ lbs

Patient's Phone _____ Physician _____

Office scheduler name: _____ Phone _____ Fax _____

Insurance: _____ Authorization # _____

Previous CT or MRI? _____ Where? _____ Date? _____

Previous PET Study? _____ Where? _____ Date? _____

Diabetic No Yes **Diabetic Medication:** _____

Allergy to contrast No Yes **Claustrophobic** No Yes
Does patient have a PowerPort No Yes
PET STUDY REQUESTED
 Standard body study (skull base to proximal thigh)

Special (non-standard) body studies

- Limited body study (e.g., chest only)
- Head and neck cancer study (skull vertex to thighs)
- Whole-body study (skull vertex to toes)
For known or suspected lower extremity tumors
(including melanoma)

 Brain only

- Alzheimers Epilepsy Tumor eval

DIAGNOSTIC CT SCANS REQUESTED

- Chest with contrast Chest without contrast
- Abdomen with contrast Abdomen without contrast
- Pelvis with contrast Pelvis without contrast
- Head with contrast Head without contrast
- Neck with contrast Neck without contrast
- Other (please specify) _____
- Check here to have no diagnostic CT performed**
- Creatinine** _____ **date drawn** _____

SPECIFIC REASON FOR PET STUDY (Check One)
Type of Cancer _____ **Histologically Proven** **Suspected**
 Diagnosis: To determine if suspicious lesion is cancer
 _____ Pulmonary nodule
 _____ Other (specify) _____

 Diagnosis: To detect an occult primary tumor:
 _____ In patient with known/suspected metastatic disease
 _____ In patient with suspected paraneoplastic syndrome

 Initial Staging of confirmed, newly diagnosed cancer

 Monitoring Response during treatment
 _____ Chemotherapy _____ Radiotherapy
 _____ Other (type) _____

 Restaging after completion of therapy
 _____ Chemotherapy _____ Radiotherapy
 _____ Other (type) _____

 Suspected Recurrence of a previously treated cancer: Site of suspected recurrence is

 based on _____

 Surveillance of a previously treated cancer in a patient with no known residual disease
(Not covered by most insurers)

Physician Signature _____ Date: _____

For scheduling, please call 616-685-4000. Please pre-register patients by calling 616-685-6094
Please FAX this form (and recent office notes, radiology reports and pathology reports) to
616-685-3038 after patient's examination has been scheduled.

Your patient is scheduled on _____ at _____
SECOND PAGE MUST BE COMPLETED FOR MEDICARE PATIENTS

Patient Name _____ DOB: _____

ADDITIONAL INFORMATION REQUIRED IF MEDICARE IS PATIENT’S PRIMARY INSURANCE

Medicare provides conventional coverage for oncologic PET studies performed for certain specific clinical indications. Most other oncologic PET studies are covered only if the referring physician provides additional information before and after the PET study as part of the National Oncologic PET Registry (NOPR) (see <http://www.cancerPETregistry.org>). If you have any questions regarding the validity of a referral, contact our physicians directly at 616-685-5907.

Please check the appropriate covered indication (or specify the requested registry-covered indication):

- Covered Cancer Diagnosis or Initial Staging:** Covered for essentially all cancer types (one study per patient per cancer) except for prostate cancer, diagnosis of breast cancer, and regional nodal evaluation of breast cancer or melanoma. Also see below.
- NOPR Cancer Diagnosis or Initial Staging:** Covered for the following cancer types (select one).
 - Cervical cancer (prior CT or MRI not performed)
 - Cervical Cancer (prior CT or MRI performed and shows extrapelvic metastasis)
 - Leukemia
- Covered Restaging/Detection of Suspected Recurrence or Treatment Monitoring:** Covered for the following cancer types (select one).
[Note that routine surveillance is not covered.]

- | | | |
|--|--|---|
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Colorectal Cancer |
| <input type="checkbox"/> Esophageal Cancer | <input type="checkbox"/> Head & Neck Cancer | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Melanoma | <input type="checkbox"/> Myeloma | <input type="checkbox"/> Non-small Cell Lung Cancer |
| <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Thyroid Cancer (with elevated thyroglobulin and negative I-131 whole-body scan) | |

- NOPR Restaging/Detection of Suspected Recurrence or Treatment Monitoring:** All other cancer types.
[Note that routine surveillance is not covered.]

REQUIRED FOR NOPR STUDIES **Ethnicity:** Hispanic Not Hispanic Unknown
Race: Asian Black or African American White or Caucasian Other Unknown

For NOPR studies, also complete and submit the pre-PET form for National Oncologic PET Registry http://www.cancerpetregistry.org/pdf/nopr_prepet_form.pdf

SECOND PAGE MUST BE COMPLETED FOR MEDICARE PATIENTS