



PET/CT IMAGING OF SAN JOSE

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POSITRON EMISSION TOMOGRAPHY (PET)/COMPUTERIZED TOMOGRAPHY (CT) REFERRAL FORM

Patient Name: _____ Tel: _____ Date: _____
Referring MD: _____ Tel: _____ Fax: _____
UPIN: _____ Insurance Company: _____
ICD9 Code: _____ Insurance Auth #: _____

PATIENT SHOULD BRING RECENT CT/MRI FILMS

PLEASE FAX to our office:

1. Patient information/ registration sheet
2. Insurance cards/ front and back
3. Recent CT/MRI/Pathology reports
4. History

REPORT INFORMATION

- STAT
 Fax Report: Fax No.: _____
 Phone Report: Phone No.: _____
 Send additional copies of report to: _____

HIGH RESOLUTION P.E.T. / CT REFERRAL

Most PET / CT studies are covered by ALL INSURANCE COMPANIES

Report Format: 8 x 10 print CD

Medicare Approved Indications:

- Alzheimer's Disease
- Cardiac / Myocardial Viability
 - Primary or initial diagnosis prior to Revascularization
 - After Inconclusive SPECT
- Breast Cancer (Staging or Restaging)
- Cervical Cancer
- Colorectal Cancer
- Esophageal Cancer
- Head and neck—Excluding CNS and thyroid
- Single Pulmonary Nodule (SPN) Requires CT/MRI.
Serial P.E.T. Scans must exceed a minimum 90-day interval & (Evaluation) characterization of Solitary Pulmonary Nodule (2.4 cm)
- Lung Cancer—Non-small cell
- Lymphoma
- Melanoma
- Refractory Seizures
- Thyroid Cancer

Other Indications:

- Unknown Primary
- Ovarian Cancer
 - Uterine Cancer
- Prostate Cancer
- Bladder Cancer
- Hepatocellular Cancer
- Cholangiocarcinoma
- Pancreatic Cancer
- Renal Cell Cancer
- Testicular Cancer
- Bone Tumor
- Brain Tumor
- Epilepsy
- Other Dementia (*Multi-infarct, Post-Traumatic, HIV, Frontal Lobe, Pick's Disease, Huntington's Disease*)
- Other _____

Please Select One: Diagnosis Staging Restaging

Is the patient diabetic? Y N

Is the patient claustrophobic? Y N

MULTI-SLICE CT SCAN REFERRAL

Report Format: 14 x 17 Film CD

- | | | | |
|--------------------------------------|---|---|--|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Please Select Contrast: | Is the patient diabetic? <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Sinus | <input type="checkbox"/> Abdomen & Pelvis | <input type="checkbox"/> With contrast | Is the patient claustrophobic? <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Without contrast | |
| <input type="checkbox"/> Head & Neck | <input type="checkbox"/> Other | <input type="checkbox"/> Both with & without contrast | |
| <input type="checkbox"/> Spine | | | |

BUN and Creatinine needed for exams with contrast

Physician Signature: _____ Date: _____