DARTMOUTH-HITCHCOCK
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# PET/CT SCAN REQUEST

PATIENT NAME_____ DOB_____ MR#_____

ORDERING PROVIDER_____ BILLING PROVIDER_____

Has this patient had a prior PET scan? Yes __ No __ If Yes, which facility?_____

As related to this disease process, has this patient had a prior: XRAY / CT / MRI? **YES** **NO** (Please circle)

If Yes, what facility? _____

Is there a problem with Claustrophobia? **YES ___ NO ___** Any Allergies to Med's **YES___ NO__.**

Is this patient a controlled diabetic? **YES _____ NO _____** Insulin? _____ Oral Medication? _____
Only patients with controlled diabetes and glucose levels <200 will be scanned.(*High glucose levels will affect scan results*.)

Patient's Height: _____ Patient's Weight: _____ (lbs. / kg) Not to exceed 350 lbs. (159 kg)

**SPECIFY PET/CT SCAN REQUEST BELOW**: All of the following use CPT Code 78815 except where noted

**Colorectal Cancer**
__ Diagnosis
__ Staging
__ Restaging

**Esophageal Cancer**
__ Diagnosis
__ Staging
__ Restaging

**Head & Neck Cancer**
__ Diagnosis
__ Staging
__ Restaging

**Lymphoma**
__ Diagnosis
__ Staging
__ Restaging

******* ***If PET/CT is for restaging – Need date of last treatment*** _____

**Lung Cancer**
__ NSCLC Diagnostic
__ NSCLC Staging
__ NSCLC Restaging
__ Single Pulmonary Nodule

**Melanoma**
__ Diagnostic (78816)
__ Staging (78816)
__ Restaging (78816)

**Breast Cancer**
__ Restaging Locoregional Recurrence
__ Staging/Restaging Distant Mets
__ Therapeutic Response Monitoring

**Thyroid Cancer**
__ Restaging

**Brain**
___Seizure (78814)
(*Preoperative Only*)

**Indication for study:**_____

**Post Surgeries**:_____

FOR RADIOLOGY ONLY

*PRE-AUTHORIZATION#*_____ *EXPIRATION DATE*_____

CPT CODE APPROVED: _____ DATE OF STUDY : _____