Department of Radiology

Dartmouth-Hitchcock MEDICAL CENTER

PET SCAN REQUEST Part 1
Please complete and fax to: **(603)-640-1956**
For telephone assistance: **(603)-650-5560**

PATIENT INFORMATION

Patient Name:_____ DOB: _____/_____/_____

☐ **Lebanon** ☐ **Lancaster** MRN:_____

Special Considerations:

☐ Blind ☐ O^2

☐ Deaf ☐ **Precautions**

☐ Disoriented ☐ Stretcher Needed

☐ IV ☐ Wheelchair Needed

Treatment*:

☐ Initial Treatment ☐ Subsequent Treatment (formally restaging and monitoring response to treatment)

☐ Male ☐ Female

☐ Pregnant ☐ Breastfeeding

Pt. Height*: _____' _____" **Pt. Weight***: _____ lbs

☐ Diabetic: ☐ Hoyer Lift

☐ Insulin: _____

☐ Oral Medication: _____

☐ **Claustrophobic**

☐ Allergies: _____

For all oncology patients aged 18-40, an oral Xanax dose of 0.5 mg will be administered by a radiology nurse 1 hour prior to the PET scan. This is to minimize muscle and brown fat activity seen on the PET scan. **A driver must accompany the patient and remain through all appointments if the patient is to receive Xanax (for claustrophobia or testing reasons).**

☐ Check here if you do NOT want your patient to receive Xanax mg. orally 1 hour prior to the PET Scan.

HISTORY

Specifically related to this disease process, has this patient had:

Prior CTs:	☐ Yes ☒ No	If yes, where:_____	Date: _____/_____/_____
Prior MRIs:	☐ Yes ☐ No	If yes, where:_____	Date: _____/_____/_____
Prior PET Scans:	☐ Yes ☐ No	If yes, where:_____	Date: _____/_____/_____

Outside Films: ☐ Pt will Hand Carry ☐ Please request **CPT Code***: _____

Has this study been pre-certified: ☐ Yes ☐ No Pre-Cert #*:_____ Exp: _____

INDICATION / REQUEST DETAILS (*Required)

Indication for study*:_____

Reason for Exam*: _____

PET Type:

☐ Standard (includes neck, chest, abdomen, and pelvis) 78815

☐ Standard plus head and neck (for head/neck cancer) 78815

☐ Entire Body, head to toes (for melanoma or where clinical concern is in extremities) 78816

☐ Prostate Standard - AXVMin

☐ Neuroendocrine Tumor - Netspot

☐ Brain Only (Dementia, seizure, brain tumor) 78608

☐ Cardiac Viability 78459

☐ Cardiac Perfusion (single) 78491

☐ Cardiac Perfusion (multiple) 78492

☐ Cardiac Sarcoid

REFERRING PROVIDER

Ordering Facility Name: _____

Ordering Facility Phone #: (_____) - _____ - _____ Provider Pager: _____

Ordering Provider Name (Print): _____

☐ Staff Physician

☐ Resident/Other

Ordering Provider Signature*: _____ Date: _____/_____/_____

FAX NUMBER: (603)-640-1956

PHONE NUMBER: (603)-650-5560

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Dartmouth-Hitchcock
MEDICAL CENTER

IMAGING REQUEST Part 2

Please complete and fax to the appropriate scheduler (see **fax** information at **lower left**.)
For telephone assistance: **(603)-650-4488**

Part 2- Clinical Decision Support for CT/MRI/Nuclear Medicine/PET Scans ONLY

Patient Name:_____ DOB: _____/_____/_____

MRN:_____

INDICATION / REQUEST DETAILS (*Required)

Reason for Exam*: _____

Decision Support Session ID*: _____

Decision Support Vendor*: _____

Decision Support Score:

- ☐ 1- Low Utility
- ☐ 2- Low Utility
- ☐ 3- Low Utility
- ☐ 4- Marginal
- ☐ 5- Marginal
- ☐ 6- Marginal
- ☐ 7- Indicated
- ☐ 8- Indicated
- ☐ 9- Indicated
- ☐ Acceptable
- ☐ Appropriate
- ☐ Inappropriate
- ☐ Indeterminate
- ☐ Moderate
- ☐ Not Validated

Decision Support Adherence:

- ☐ No
- ☐ No Criteria Available
- ☐ Yes

For more information visit:
http://nationaldecisionsupport.com/pama/

REFERRING PROVIDER

Ordering Facility Name: _____

Ordering Facility Phone #: (_____) - _____ - _____ Date: _____/_____/_____

Ordering Provider Name (Print): _____

FAX NUMBERS

CT*	(603)-640-1956
Diagnostic X-Ray	(603)-640-1967
Mammography / DXA*	(603)-640-1944
MRI*, Nuclear Medicine	(603)-640-1956
Ultrasound	(603)-640-1944
VIR (Angiography)	(603)-640-1966
Fluoro	(603)-640-1965

PHONE NUMBERS

CT	(603)-650-7452
Diagnostic X-Ray	(603)-650-4482
Mammography	(603)-650-8260
DXA	(603)-653-9388
MRI	(603)-650-8445
Nuclear Medicine	(603)-650-5560
Ultrasound	(603)-650-7451
VIR (Angiography)	(603)-650-7464