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

☐ Diabetic: ☐ Hoyer Lift
☐ Insulin: ____________________________
☐ Oral Medication: ____________________
☐ **Claustrophobic**
☐ Allergies: ________________________________

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

☐ Male ☐ Female
☐ Pregnant ☐ Breastfeeding

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

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
☐ PSMA Prostate (Pylarify)
☐ Neuroendocrine Tumor (Detectnet)
☐ 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): ____

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

☐ Staff Physician
☐ Resident/Other

FAX NUMBER: (603)-640-1956 **PHONE NUMBER: (603)-650-5560**

This is Part 1 of 2 pages, please make sure to fill out ***Part 2- Clinical Decision Support for CT/MRI/NM/PET***

Updated 2/10/22

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