DIAGNOSTIC IMAGING SERVICES

PET/CT REFERRAL FORM

A Registered National Oncologic PET Registered Facility **Scheduling: (F) 504-883-5364 • (P) 504-883-5999**

Today's Date _____ Date & Time of Procedure _____

Patient Name _____ Gender ___ D.O.B. _____ Wt _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____

Date of patient's last Chemo or Radiation Treatment _____ Reason for Exam _____

Primary Care Physician _____ Phone _____

Ordering Physician _____ Phone _____ Fax _____

Ordering Physician's Signature _____

Office the Report is being sent to _____

INITIAL TREATMENT STRATEGY – DIAGNOSIS & INITIAL STAGING

Please check appropriate indications, adding the 4th or 5th digit

☐ Anus	154._____	☐ Bladder	188._____	☐ Bone/cartilage	170._____
☐ Cervix	180._____	☐ Colon	153._____	☐ Connective/other soft tissue	171._____
☐ Esophagus	150._____	☐ Rectum	154._____	☐ Female breast	174._____
☐ Gallbladder/extrahepatic bile ducts	156._____	☐ Eye	190._____	☐ Kidney and other urinary tracts	189._____
☐ Larynx	161._____	☐ Kaposi's Sarcoma	176._____	☐ Liver and intrahepatic bile ducts	155._____
☐ Lung, non-small cell	162._____	☐ Lip, Oral Cavity & Pharynx	140-149._____	☐ Lymphoma	200-202._____
☐ Male breast	175._____	☐ Lung, small cell	162._____	☐ Metastatic/unknown origin	106-199._____
☐ Myeloma	203._____	☐ Melanoma	172._____	☐ Neuroendocrine tumor	209._____
☐ Non-melanoma skin	173._____	☐ Naval cavity, ear & sinuses	160._____	☐ Other & specified nervous system	192._____
☐ Other endocrine glands & related structures	194._____	☐ Other & unspecified female genitalia	184._____	☐ Pancreas	157._____
☐ Penis & other male genitalia	187._____	☐ Ovary	183._____	☐ Pleura	163._____
☐ Primary brain	191._____	☐ Placenta	181._____	☐ Small intestine	152._____
☐ Single Pulmonary Nodule – Characterization ☐ Thymus, heart, mediastinum	164._____	☐ Retro peritoneum and peritoneum	158._____	☐ Testis	186._____
☐ Uterus, Body	182._____	☐ Stomach	151._____	☐ Uterine adnexa	183.2-183.9._____
☐ Uterus, Unspecified	179._____	☐ Thyroid	193._____	☐ 18F Sodium Fluoride (NaF) Bone Scan	

SUBSEQUENT TREATMENT STRATEGY – TREATMENT MONITORING, RESTAGING & REOCCURENCE

☐ Cervix	180._____	☐ Colon	188._____	☐ Thyroid	193._____
☐ Female breast	174._____	☐ Rectum	154._____	☐ Esophagus	150._____
☐ Lung, non-small cell	162._____	☐ Larynx	161._____	☐ Lip, oral cavity & pharynx	140-149._____
☐ Melanoma	172._____	☐ Lymphoma	200-202._____	☐ Male breast	175._____
☐ Ovary	183._____	☐ Myeloma	203._____	☐ Nasal cavity, ear & sinuses	160._____

BRAIN IMAGING – METABOLIC EVALUATION, DEMENTIA & ALZHEIMER'S DISEASE

☐ Dementia	290.0-290.9_____	☐ Dementia with behavioral disturbance	294.10 _____	☐ Alzheimer's Disease	331.0
☐ Dementia-front-temporal	331.19_____	☐ Dementia w/o behavioral disturbance	294.11		

DIAGNOSIS ICD-10 CODE: _____

CPT CODE: ☐ **78814 - Limited** ☐ **78815 - Mid Skull to Thighs** ☐ **78816 - Whole Body (Melanoma only)** ☐ **78608 - Brain (Dementia & ALZ)**

*** Insurance Information ***

Primary Insurance Name _____

Name on Insurance Card _____

Relationship to PT _____

Insurance Address _____

Insurance Phone _____

ID# _____ Group # _____

Secondary Insurance Name _____

Name on Insurance Card _____

Relationship to PT _____

Insurance Address _____

Insurance Phone _____

ID# _____ Group# _____

Pre-Certification / Authorization Number _____

Fax all of the following information with the scheduling request: 1) Most recent imaging report 2) Pathology report; 3) Physicians progress note (if needed for medical necessity)

Appointment Location: **Marrero**: 925 Avenue C