Tri-City PETCT at Vista

Your Partner in Quality Diagnostic Imaging

APPOINTMENT

Date: Time:

902 Sycamore Avenue • Suite 120
Vista, CA 92081
TRICITYPETCT.COM

PET/CT Form

Scheduling: **760.599.9940**
Fax: **760.599.0885**
TIN: **26-2628732**

Please fill out completely.

Date: _____

Referring Provider: _____ NPI: _____

Provider's Signature: _____

Contact Person: _____

Phone: _____ Fax: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____

DOB: _____ Ht: _____ Wt: _____

Home Phone: _____ Alt Phone: _____

Insurance Company: _____ Authorization #: _____

Diagnosis: _____ ICD Code: _____

Diabetic: ❑ Yes ❑ No Radiation Treatment Planning: ❑ Yes ❑ No

Allergies: ❑ Yes ❑ No If Yes, list: _____

Reason for Study:

- ❑ Diagnosis
- ❑ Staging
- ❑ Restaging
- ❑ Monitoring Response to Treatment

PET/CT Scan:

- ❑ Skull to Thigh 78815
- ❑ Whole Body 78816 (melanoma, sarcoma, etc.)
- ❑ Brain Imaging 78608
- ❑ Cardiac Viability 78459
- ❑ Axumin A9588
- ❑ NETSPOT A9587

If Medicare choose one of the following uses of PET/CT:

INITIAL TREATMENT

- ❑ Stage unknown from MR, CT or Ultrasound and course of treatment will differ depending on results of PET/CT
- OR
- ❑ Conventional imaging not sufficient for clinical management and course of treatment will differ depending on results of PET/CT

- ❑ Patient not amenable to invasive diagnostic procedure
- OR
- ❑ Determining optimal anatomical location to perform invasive diagnostic procedure

SUBSEQUENT TREATMENT

Patient **STATUS POST TREATMENT *AND:***

- ❑ Suspect recurrence
- OR
- ❑ Checking for residual disease

OR ❑ Patient has known recurrence

OR ❑ PET/CT replaces other imaging when it is expected that conventional study is insufficient for clinical management

OR

❑ Other: _____

Retain a copy of this form in the patient's medical record. Please fax front and back of insurance card.
Please fax all reports and notes pertinent to the diagnosis.

Thank you for your referral.