PET SCHEDULING
TEL: 877-877-8455
FAX: 866-927-0079

PET IMAGING

Does patient give consent to release information to immediate family members? ❑ **YES** ❑ **NO**

Do you want a CD for this patient? ❑ **YES** ❑ **NO**

Check Location

❑ Brighton - Steward St. Elizabeth's Medical Center
❑ Brockton - Steward Good Samaritan Medical Center
❑ Dorchester - Steward Carney Hospital
❑ Fall River - Saint Anne's Hospital
❑ Foxboro - Steward Foxboro
❑ Holyoke - Holyoke Medical Center
❑ Milton - Milton Hospital
❑ North Dartmouth - Hawthorn Medical Associates
❑ Northampton - Cooley Dickinson Hospital
❑ Westfield - Noble Hospital
❑ Ayer - Nashoba Valley Medical Center

Patient Information

Interpreter needed? ❑ Yes ❑ No Language _____ MR#: _____

[1.] Patient Name (please print)				[2.] Patient Telephone #	[3.] Alternate Phone #
Last First					
[4.] Patient Address (Street, City and ZIP)					
[5.] Patient Sex	[6.] Date of Birth	[7.] Height	[8.] Weight	[9.] Pregnant or Breastfeeding	[10.] Diabetic
❑ M ❑ F				❑ Yes ❑ No LMP date:	❑ Yes ❑ No ❑ Insulin ❑ Pills
[11.] Practice Name (please print)				[12.] Practice Telephone #	[13.] Practice Fax #
[14.] Ordering Physician Name (please print)				[15.] Ordering Contact Name (please print)	
Last First					
[16.] Practice Address (Street, City and ZIP)					
[17.] Name of Insurance Co.	[18.] Insurance Co. Phone #	[19.] Subscribers Insurance ID		[20.] Insurance Prior Author. #	
[21.] Secondary Insurance Co.	[22.] Insurance Co. Phone #	[23.] Subscribers Insurance ID		[24.] Insurance Prior Author. #	

*****Physician's Signature _____ Date: _____

Clinical History

Choose one:
❑ **Standard PET/CT (skull base to mid thigh, CPT 78815)**
❑ **Whole Body PET/CT (for Melanoma and NaF Bone, CPT 78816)**
❑ **Brain PET/CT (CPT 78608)**

Choose one:
❑ **Diagnosis**
❑ **Staging - Send Pathology Report**
❑ **Re-Staging**
❑ **Response to Therapy**

[1.] Diagnosis		
[2.] Indication		
[3.] Why is PET Scan being performed?	[4.] How Soon Needed?	[5.] STAT REPORT
		❑ Yes ❑ No
[6.] Previous Imaging Exams/Pathology	Please Fax Reports ❑ CT ❑ MRI ❑ PET	
Where:	When:	

Do not write below this line - office use only

AM BS:_____ Exam Type: _____ Insurance Verified ❑ Account # _____
Scheduled/Prepped ❑ Outside Films ❑ Pre-registered ❑ Called MD with Appointment Date ❑ # of Oral Contrast Bottles _____
Dorse: _____ mCi FDG Time Administered: _____ Injection Site: _____ BS: _____ Initials: _____