Mallinckrodt Institute of Radiology - Barnes-Jewish Hospital
Physician Request Form for Oncologic PET/CT Imaging

Patient Name _____ Date of Study _____

DOB _____ Social Security No. _____ Gender _____ Weight _____ lbs

Patient's Address _____

City, State, Zip _____ Patient's Phone _____

Physician _____ Physician's Phone/Pager _____

Type of Insurance: _____ Precert. # (if applicable) _____

Previous CT or MRI? _____ Where? _____ Date? _____

Previous PET Study? _____ Where? _____ Date? _____

Diabetic No ☐ Yes ☐ Diabetic Medication: _____

STUDY REQUESTED (Check One)

☐ Standard body study (skull base to proximal thigh)

Special (non-standard) body studies

- ☐ Limited body study (e.g., chest only)
- ☐ Head and neck cancer study (skull vertex to thighs)
- ☐ Whole-body study (skull vertex to toes)
  For known or suspected lower extremity tumors (including melanoma)

☐ Brain only (for brain tumor)

INSTRUCTIONS FOR MD OFFICE AND PATIENT

- Low carbohydrate diet on day before study
- No food after midnight if study time is before 1:00 p.m.
- No food after 7:00 a.m. if study time is after 1:00 p.m. (patient may eat a light breakfast before 7:00 a.m.)
- Drink only water on day of study
- Foley catheter will be placed prior to body PET study if pelvic disease considered likely
- Patient must bring outside films

SPECIFIC REASON FOR PET STUDY (Check One)

Type of Cancer_____ ❑ **Histologically Proven** ❑ **Suspected**

❑ **Diagnosis**: To determine if suspicious lesion is cancer
_____Pulmonary nodule
_____Other (specify)_____

❑ **Diagnosis/Unknown Primary Tumor**: To detect primary tumor in patient with confirmed/suspected metastatic lesion

❑ **Diagnosis/Paraneoplastic**: To detect a primary tumor site in patient with a presumed paraneoplastic syndrome

❑ **Initial Staging** of histologically confirmed, newly diagnosed cancer

❑ **Monitoring Response** during treatment
_____Chemotherapy
_____Radiotherapy
_____Other (type)_____

❑ **Restaging** after completion of therapy
_____Chemotherapy
_____Radiotherapy
_____Other (type)_____

❑ **Suspected Recurrence** of a previously treated cancer

Additional History or Instructions: _____

_____

Physician Signature _____

For scheduling, please call 362-4PET (362-4738) or 888-362-4PET (888-362-4738)
Please FAX this form (and recent office notes, radiology reports and pathology reports) to 362-1032 after patient's examination has been scheduled.

SECOND PAGE MUST BE COMPLETED FOR MEDICARE PATIENTS

Check for current form and patient brochure at:
http://gamma.wustl.edu/division/clinical-information.html

Revised 15-October-07

ADDITIONAL INFORMATION REQUIRED IF MEDICARE IS PATIENT'S PRIMARY INSURANCE

Medicare provides conventional coverage for oncologic PET studies performed for certain specific clinical indications. Most other oncologic PET studies are covered only if the referring physician provides additional information before and after the PET study as part of the National Oncologic PET Registry (NOPR) (see http://www.cancerPETregistry.org). **If you have any questions regarding the validity of a referral, contact our physicians directly at (314) 362-4PET (362-4738) or (888) 362-4PET.**

Please check the appropriate covered indication (or specify the requested registry-covered indication):

COVERED	Diagnosis	Initial Staging	Restaging/ Suspected Recurrence	Treatment Monitoring
Non-small Cell Lung Cancer	☐	☐	☐	
Colorectal Cancer	☐	☐	☐	
Melanoma	☐	☐	☐	
Lymphoma	☐	☐	☐	
Head and Neck Cancer (excluding brain/thyroid tumors)	☐	☐	☐	
Esophageal Cancer	☐	☐	☐	
Breast Cancer		☐	☐	☐
Thyroid Cancer (I-131 negative/thyroglobulin positive)			☐	
Cervical Cancer (negative CT or MRI for extrapelvic metastasis)		☐		
ELIGIBLE UNDER NOPR All other cancers and all other indications Specify Cancer: _____	☐	☐	☐	☐

Also complete and submit the pre-PET form for National Oncologic PET Registry
http://www.cancerpetregistry.org/pdf/nopr_prepet_form.pdf

REQUIRED FOR NOPR Ethnicity: ❑ Hispanic ❑Not Hispanic ❑Unknown

Race: ❑ Asian ❑ Black or African American ❑ White or Caucasian ❑ Other ❑ Unknown

Physician Signature _____ Date: _____

(A ***physician's*** signature is required)

Patient Name _____ DOB: _____

SECOND PAGE MUST BE COMPLETED FOR MEDICARE PATIENTS