Mallinckrodt Institute of Radiology - Barnes-Jewish Hospital
Physician Request Form for Brain PET Imaging

Patient Name _____ Birthdate _____

Social Security No. _____ Gender _____

Address _____

City, State, Zip _____ Physician _____

Patient's Phone _____ Physician's Phone/Pager _____

Date of Study _____ Type of Insurance: _____

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

Previous PET Study? _____ Where? _____ Date? _____

Diabetic No ☐ Yes ☐ Diabetic Medication: _____

Medicare will only reimburse for brain PET studies performed for certain specific clinical indications. Thus, for Medicare patients, it is important to ensure that your referral qualifies for reimbursement according to the specific criteria detailed below. If these criteria are not met, we are still quite willing to accommodate your request, but we will be required to bill the patient directly. **If you have any questions regarding the validity of a referral, contact our physicians directly at 314-362-4PET (314-362-4738) or 888-362-4PET.**

SPECIFIC REASON FOR BRAIN PET STUDY (CHECK ONE)

☐ **Intractable seizure being evaluated for possible surgery (Covered by Medicare)**

☐ **Dementia (Possibly covered by Medicare; must complete pages 2 and 3 for Medicare patient)**

☐ **Other (Noncovered)** _____

Use the "Physician Request Form for Oncologic PET Imaging" for brain tumor evaluation.

INSTRUCTIONS FOR PHYSICIAN'S OFFICE AND PATIENT

- No food after midnight for study scheduled before 1:00 p.m.
- No food after 7:00 a.m. for study scheduled after 1:00 p.m. (patient may eat a light breakfast before 7:00 a.m.)
- Drink only water on day of study
- Patient must bring outside films
- Call for instructions for diabetic patients

Additional History or Instructions: _____

_____

Physician Signature _____

For scheduling, please call 314-362-4PET (314-362-4738) or 888-362-4PET (888-362-4738)
Please FAX this form (and recent office notes, radiology reports and pathology reports) to 314-362-1032 after patient's examination has been scheduled.

COMPLETE PAGES 2 AND 3 ONLY IF STUDY IS DEMENTIA ASSESSMENT IN A MEDICARE PATIENT

Physician Request Form for Brain PET Imaging for Dementia

ADDITIONAL INFORMATION REQUIRED FOR MEDICARE PATIENTS

Patient Name _____ **Birthdate** _____

Important: Please ensure that your referral qualifies for Medicare reimbursement according to the specific criteria detailed below. See http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=104 for more information. Medicare regulations require that we collect this information before performing the study. If the required information is not provided, we are certainly able to accommodate your request, but your patient will be billed for the examination (total charges nearly $3,200). If you have any concerns regarding the validity of a referral for Medicare reimbursement, contact **our physicians directly at (314) 362-2802**.

Please initial each of the following:
I personally attest to the following and confirm that I have documentation to support the following:

Initials

☐ The patient has a recent diagnosis of dementia (with a documented cognitive decline for at least 6 months) that meets criteria for both Alzheimer's disease (AD) and frontotemporal dementia (FTD).

☐ The onset, clinical presentation, or course of cognitive impairment is such that FTD is suspected as an alternative neurodegenerative cause of the cognitive decline.

☐ The patient has been evaluated for specific alternative neurodegenerative diseases and the cause remains uncertain.

☐ The patient has had a comprehensive clinical evaluation (as defined by the American Academy of Neurology) encompassing a medical history from the patient and a well-acquainted informant (including assessment of activities of daily living), physical and mental status examination (including formal documentation of cognitive decline occurring over at least six months) aided by cognitive scales or neuropsychological testing, laboratory tests, and structural imaging such as magnetic resonance imaging (MRI) or computed tomography (CT).

☐ The evaluation did not clearly determine a specific neurodegenerative disease or other cause for the clinical symptoms, and information available through FDG-PET is reasonably expected to help clarify the diagnosis between FTD and AD and help guide future treatment.

☐ The patient has been evaluated by a physician experienced in the diagnosis and assessment of dementia.

☐ A brain single-photon emission computed tomography (SPECT) or FDG-PET has NOT previously been obtained for the same indication, or was obtained more than one year ago and was inconclusive.

All other uses of FDG-PET for patients with a presumptive diagnosis of dementia-causing neurodegenerative disease (e.g., possible or probable AD, clinically typical FTD, dementia of Lewy bodies, or Creutzfeld-Jacob disease) for which CMS has not specifically indicated coverage continue to be noncovered.

Please provide ALL of the following required specific information:

Date of onset of symptoms: _____

Mini mental status exam (MMSE) or similar test score: _____

Specify test if not MMSE: _____

Report from any neuropsychological testing performed (please summarize): _____

_____

_____

_____

Diagnosis of clinical syndrome (check appropriate box):

Dementia: ☐ Mild ☐ Moderate ☐ Severe ☐ Mild cognitive impairment ☐ **Other (specify)** _____

Presumptive cause (check appropriate box): ☐ Uncertain AD ☐ Possible AD ☐ Other _____

Results of CT or MRI (summarize or send a copy of report) _____

_____

_____

_____

Relevant laboratory tests (B12, thyroid function tests, other) _____

Vitamin B12: _____

Thyroid Function Tests: _____

Other (specify): _____

List all prescribed medications:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

By signing this request form I acknowledge full responsibility for the information that must be maintained in this patient's medical record in my office. I have verified that all conditions described above have been met. Upon request I will make this documentation available to the provider and/or to CMS, its agents or other authorized personnel for review.

Physician Signature _____ Date _____

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

Patient Name _____ DOB: _____