

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

Patient Name _____ DOB _____

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:** _____

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

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	Treatment Monitoring
Non-small Cell Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colorectal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Head and Neck Cancer (excluding brain/thyroid tumors)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Esophageal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Breast Cancer		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Cancer (I-131 negative/thyroglobulin positive)			<input type="checkbox"/>	
Cervical Cancer (negative CT or MRI for extrapelvic metastasis)		<input type="checkbox"/>		
ELIGIBLE UNDER NOPR All other cancers and all other indications Specify Cancer: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Unknown Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Other <input type="checkbox"/> Unknown				

Physician Signature _____ Date: _____
 (A *physician's* signature is required)

Patient Name _____ DOB: _____

SECOND PAGE MUST BE COMPLETED FOR MEDICARE PATIENTS