

**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: To detect an occult primary tumor:
In patient with known/suspected metastatic disease
In patient with suspected paraneoplastic syndrome

Initial Staging of 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: Site of suspected recurrence is _____
based on _____

Surveillance of a previously treated cancer in a patient with no known residual disease
(Not covered by most insurers)

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 Cancer Diagnosis or Initial Staging: Covered for essentially all cancer types (one study per patient per cancer) except for prostate cancer, diagnosis of breast cancer, and regional nodal evaluation of breast cancer or melanoma. Also see below.

NOPR Cancer Diagnosis or Initial Staging: Covered for the following cancer types (select one).

- Cervical cancer (prior CT or MRI not performed)
- Cervical Cancer (prior CT or MRI performed and shows extrapelvic metastasis)
- Leukemia

Covered Restaging/Detection of Suspected Recurrence or Treatment Monitoring: Covered for the following cancer types (select one).

[Note that routine surveillance is not covered.]

- Breast Cancer
- Esophageal Cancer
- Melanoma
- Ovarian Cancer
- Cervical Cancer
- Head & Neck Cancer
- Myeloma
- Thyroid Cancer (with elevated thyroglobulin and negative I-131 whole-body scan)
- Colorectal Cancer
- Lymphoma
- Non-small Cell Lung Cancer

NOPR Restaging/Detection of Suspected Recurrence or Treatment Monitoring: All other cancer types. *[Note that routine surveillance is not covered.]*

REQUIRED FOR NOPR STUDIES

Ethnicity: Hispanic Not Hispanic Unknown

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

For NOPR studies, also complete and submit the pre-PET form for National Oncologic PET Registry

http://www.cancerpetregistry.org/pdf/nopr_prepet_form.pdf

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

Patient Name _____ DOB: _____

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