The Regional Cancer Center

In affiliation with UPMC CancerCenter

Today's Date:_____

Patient Name:_____

Address:_____

_____

Email Address:_____

☐ Unknown at this time ☐ None ☐ Declined

RCC#: _____

Social Security#: _____

DOB: _____

Phone: _____

PET/CT
Scheduling Request

Please FAX form to: 814-836-2648
Phone: 814-836-2642

Check In Time:_____

Date of Service:_____

Please Select from Each Section

Section 1 **PET Orders for PET Scan (Select One Box Only)**

☐Standard Scan (skull base through mid thigh) Auth#: _____ Exp.:_____.

☐ Whole Body Scan (head through toes-Melanoma & Multiple Myeloma patients only) Auth#: _____ Exp.:_____.

☐ PET Limited Scan (select up to 3 areas below for limited study) Auth#: _____ Exp.:_____.

☐ Neck ☐ Chest ☐Abdomen ☐ Pelvis

☐ PET Brain Only Auth#: _____ Exp.:_____.

Section 2 **CT Orders to Correlate with PET (Select All That Apply)**

☐ CT for PET Attenuation Correction ONLY (no CT report given)

☐ Diagnostic CT – CT Report with be given – Choose Areas Below:

☐ Diagnostic (neck) Auth#: _____ Exp.:_____.

☐ Diagnostic (chest) Auth#: _____ Exp.:_____.

☐ Diagnostic (abdomen) Auth#: _____ Exp.:_____.

☐ Diagnostic (pelvis) Auth#: _____ Exp.:_____.

☐ IV Contrast: ☐ Yes ☐No

All diagnostic CT orders with IV contrast must have labs completed within 4 weeks of scheduled exam.

Date Drawn:_____ ☐BUN:_____. ☐GFR:_____. ☐Creatinine:_____.

Section 3 **Select One**

☐ Initial treatment decision making for Bx. Proven or strongly suspected cancerous tumor

☐ Subsequent treatment decision making for treatment monitoring, restaging, suspected recurrence, etc.

Diagnosis:_____.

CPT Code:_____. ICD 10 Code:_____.

Standard Scan with Attenuation – 78815 Standard Scan with Diagnostic CT's – 78812

Whole Body with Attenuation – 78816 Whole Body with Diagnostic CT's – 78813

Limited Scan with Attenuation – 78814 Limited Scan with Diagnostic CT's – 78811

Brain Scan for Metabolic Evaluation for Dementia, Oncology and Epilepsy – 78608

Scheduling Comments:_____.

Section 4 **Insurance Information**

Primary Insurance:_____. Secondary Insurance:_____.

ID #:_____. ID #:_____.

Group #:_____. Group #:_____.

If no auth required, name of person spoken to:_____.

Section 5 **FAX all of the following information with scheduling request:**

☐Most recent imaging report ☐Pathology report ☐Labs (within 4 weeks) when ordering diagnostic CT

☐Physician progress note

Section 6 **MUST be filled out completely**

MD Name (print):_____. MD Signature:_____.

Office Phone:_____. Office Contact:_____.