COMMUNITY
CANCER CENTER

❑ **NORTH FLORIDA**
7000 NW 11th Place ▪ Gainesville, Florida 32605
(352) 331-0900 ▪ Fax (352) 331-1511

❑ **LAKE-CITY**
4520 West US Hwy 90 ▪ Lake City, Florida 32055
(386) 755-0601 ▪ Fax (386) 755-0602

PET/CT SCAN REQUEST FORM

Patient Name:		DOB: / /
Home:	Work:	Mobile:
ICD-9 Code(s):		
Social Security Number:		
Ordering Physician:	Phone:	Fax:
Follow-up Appointment Date:		

Order: Integrated PET/CT scan utilizing a non-contrast diagnostic CT

❑ Standard Body (eyes to thighs protocol)	78815	❑ Brain (primary brain tumor protocol)	78608
❑ Whole Body (head to toe protocol)	78816	❑ Dementia	78608
❑ Standard Body with Brain (for known or suspected brain mets)	78815	❑ Characterization of a Solitary Pulmonary Nodule	78815
		❑ Limited Study (physician defined protocol)	78814

Reason for ordering a PET/CT scan:

❑ Diagnosis	❑ Staging (pre-treatment)
❑ Restaging (post-treatment)	❑ Treatment Monitoring/Treatment Assessment
RE-STAGING: *Using PET/CT after an entire course of therapy is completed to see if the treatment worked or if there is persistent disease. Re-staging should be used when a physician is trying to identify a recurrence.*	***TREATMENT ASSESSMENT:*** *Using PET/CT to scan a patient during a planned course of chemotherapy or radiation therapy to see if the therapy is working and determine if the patient should continue on the same course of therapy.*
	❑ Radiation Therapy Treatment Planning

Questions:

Is patient currently undergoing a planned course of therapy? ❑ Y ❑ N ❑ Chemotherapy ❑ Radiation Therapy

When is the patient's next treatment? _____ ❑ N/A

Please attach the following:

- Clinical/Office/Surgical Notes
- Pathology Report
- Labs
- Patient Demographic Data
- Copy of Insurance Card
- Imagery Reports - *please mark below which one(s) are attached*

❑ Bone Scan ❑ Chest X-ray ❑ MRI ❑ CT ❑ PET/CT (*Previous Date* _____) ❑ Other

Physician Signature **Date**

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CT SCAN REQUEST FORM

Patient Name:		DOB: / / M F (circle one)
Home:	Work:	Mobile:
ICD-9 Code(s):		Diagnosis:
Patient Address:	City:	Zip:
Ordering Physician:	Phone:	Fax:
Follow-up Appointment Date:		

Order: Diagnostic CT

	70450	CT head or brain w/o		72130	CT thoracic spine w & w/o
	70460	CT head or brain w		72131	CT lumbar spine w/o
	70470	CT head or brain w & w/o		72132	CT lumbar spine w
	70480	CT orbit; sella; inner ear w/o		72133	CT lumbar spine w & w/o
	70481	CT orbit; sella; inner ear w		72192	CT pelvis w/o
	70482	CT orbit; sella; inner ear w & w/o		72193	CT pelvis w
	70486	CT maxillofacial w/o		72194	CT pelvis w & w/o
	70487	CT maxillofacial w		73200	CT upper extremity w/o
	70488	CT maxillofacial w & w/o		73201	CT upper extremity w
	70490	CT soft tissue neck w/o		73202	CT upper extremity w & w/o
	70491	CT soft tissue neck w		73700	CT lower extremity w/o
	70492	CT soft tissue neck w & w/o		73701	CT lower extremity w
	71250	CT thorax w/o		73702	CT lower extremity w & w/o
	71260	CT thorax w		74150	CT abdomen w/o
	71270	CT thorax w & w/o		74160	CT abdomen w
	72125	CT cervical spine w/o		74170	CT abdomen w & w/o
	72126	CT cervical spine w		76370	CT for radiation therapy fields
	72127	CT cervical spine w & w/o		76376	3D rendering w/o post process
	72128	CT thoracic spine w/o		76377	3D rendering w/post process
	72129	CT thoracic spine w		76380	CT limited or localized follow-up

Reason for Ordering a Diagnostic CT Scan:

_____

_____

_____

_____ _____

Physician Signature **Date**

Please provide a copy of the patient demographic data along with a copy of their insurance.