

Augusta Health

PHYSICIAN ORDER FORM

PET CT Imaging

P.O. Box 1000 Fishersville, Va. 22939

Nuclear Medicine

Scheduling (540) 332-4400

Patient Name _____ Date of Birth _____ Exam Date _____

Patient Contact Phone () _____ Weight _____ Height _____ Pre-cert # _____

Reason for Scan _____

ICD Code (required) _____

Is patient diabetic/insulin dependent? Yes ___ No ___ If yes, how is it controlled? _____

PET Exam requested due to prior abnormal diagnostic test (please check all that is appropriate)

Abnormal X-ray Abnormal CT Biopsy Proven

Previous Scans/ Therapies	Date Performed	Facility Performed
PET _____	_____	_____
CT _____	_____	_____
MRI _____	_____	_____
Nuc Med _____	_____	_____
Radiation Therapy _____	_____	_____
Chemotherapy _____	_____	_____

Please checkmark appropriate study below

(Note that initial study now includes initial staging as well as a diagnosis study)

Initial	Restaging	PET Scan	CPT	Initial	Restaging	PET Scan	CPT
_____	_____	Breast	78815	_____	_____	Brain Dementia (Metabolic)	78608
_____	_____	Colorectal	78815	n/a	_____	Prostate Restaging FDG	78815
_____	_____	Esophageal	78815	n/a	_____	Prostate Restaging Axumin	78815
_____	_____	Head & Neck	78815	_____	_____	Prostate Pylarify	78815
_____	_____	Single Pulmonary Nodule	78815	_____	_____	Solid Tumor (check appropriate exam below)	78815
_____	_____	Leukemia CLL	78816	<input type="checkbox"/> Cervix <input type="checkbox"/> Ovary <input type="checkbox"/> Pancreas <input type="checkbox"/> Sarcoma <input type="checkbox"/> Testes Other _____			
_____	_____	Lung	78815	_____	_____	GA68 or CU64 Neuroendocrine Tumor	78815
_____	_____	Lymphoma	78815	_____	_____	F18 NaF Tumor Bone (non-registry)	78816
_____	_____	Lymphoma T-Cell	78816	Other (list in below-be specific) _____ _____ _____			
_____	_____	Melanoma	78816				
_____	_____	Myeloma	78816				
_____	_____	Thyroid	78815				
_____	_____	Merkel	78816				

Sedation: *May we administer (circle)*
 Toradol 30 mg IM

Alprazolam 0.5 mg
 Toradol 60 mg IM

Alprazolam 1 mg
 Other _____

Physician Signature _____ Date _____ Time _____

Physician Phone (____) _____ Fax (____) _____