Oncology PET/CT REFERRAL DATA SHEET

Center for Molecular Imaging and Therapy

Please note new location and contact information for CMIT

2120 Kings Highway
Scheduling: 318-716-4001
Fax: 318-716-4075

PATIENT NAME: _____
print

PHYSICIAN: _____ _____
print signature of referring physician

PRIORITY (check one): _____ **ROUTINE (for restaging and follow up scans)**
_____ **ASAP (for staging, treatment or surgery planning)**
_____ **SPECIFIC DATE**: _____

DIAGNOSIS: (include histology and date): _____
Site involved at diagnosis: _____
Stage at diagnosis (AJCC or FIGO, TNM best): _____

SURGERY: (include type and date): _____
_____

RADIATION THERAPY (include inclusive dates):_____
_____

CHEMOTHERAPY (with inclusive dates, including completion date of most recent course):
_____

REASON FOR SCAN
(DESIRED INFORMATION): _____
_____
_____

I verify that this office has used Appropriate Use Criteria before ordering this PET/CT Scan: ☐ Yes ☐ No

This office has requested pre-authorization for CPT 78815 (skull to mid-thigh) or CPT 78816 (top of skull to toes) and HCPCS A9552. ☐ Yes ☐ No

In order to provide you with the maximum possible information from your patient's PET/CT scan, it is critical that the clinical data on this form be available to the physician at the time of the study. It should be supplemented with copies of an appropriate history and physical or clinical notes, copies of recent diagnostic imaging reports and relevant laboratory data (e.g. tumor marker levels), as well as results of recent biopsy or surgical pathology. **Patients cannot be scheduled without the information on this form being complete and signed by the referring physician (required by CMS (Medicare) and private insurance carriers).**

Person faxing information: _____ **Phone #** _____