



**P E T**  
Positron Emission Tomography

# PET/CT Written Order Form F18- FDG Imaging

To schedule PET/CT studies: 1-866-258-4PET (4738) or fax form to: 1-888-662-4700

## Baystate MRI & Imaging Center

80 Wason Avenue  
Springfield, MA 01107  
Tax ID: 04-3454301

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone #: \_\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Diagnosis/ICD-9 Code: \_\_\_\_\_

Previous CT/MRI – Where: \_\_\_\_\_

<b>Solitary Pulmonary Nodule</b> <input type="checkbox"/> Characterization	<b>Lung Cancer</b> <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment	<b>Lymphoma</b> <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment	<b>Colorectal Cancer</b> <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment
<b>Esophageal Cancer</b> <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment	<b>Head and Neck Cancer</b> <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment	<b>Breast Cancer</b> <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment	<b>Melanoma</b> <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment
<b>Thyroid Cancer</b> <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment	<b>Cervical Cancer</b> <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment	<b>Myeloma</b> <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment	<b>Ovarian Cancer</b> <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment
<b>Brain Imaging</b> <input type="checkbox"/> Evaluation of tumor recurrence <input type="checkbox"/> Refractory Seizures <input type="checkbox"/> Alzheimer's Disease	<b>Tumor Imaging</b> <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Subsequent Treatment Tumor type _____	<b>Bone Imaging</b> <input type="checkbox"/> 18F-FDG <input type="checkbox"/> 18F-Sodium Fluoride	<b>Myocardial Imaging</b> <input type="checkbox"/> Metabolic Evaluation
<b>Immobilization Device</b> <input type="checkbox"/> Head Cup <input type="checkbox"/> Mask	<b>Arm Position</b> <input type="checkbox"/> Arms Up <input type="checkbox"/> Arms Down	<b>Other</b> <input type="checkbox"/> 3mm CT slices <input type="checkbox"/> _____	

Physician's Signature: \_\_\_\_\_ Phone #: \_\_\_\_\_

Physician's Name (please print): \_\_\_\_\_ Fax #: \_\_\_\_\_

Billing Information/Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_

Pre-Authorization #: \_\_\_\_\_

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM PM Location: \_\_\_\_\_

*By signing this request form, I acknowledge full responsibility for the information that must be completed and maintained in this patient's medical record in my office. I have verified that all conditions described above have been met. Upon request I will make this documentation available to the provider and/or to CMS, its agents or other authorized personnel for review.*

**Please have patient bring any previous CT, MRI, PET films with them to their appointment.**