



The following form must be completely filled out and faxed to (701) 234-6072 before a patient will be given a scan date and time. If you have any questions please call (701) 234-7100.

Referring Physician PET/CT - Ordering Form

Patient Information:

Patient Name: _____ Date of Birth: ____/____/____

Home Phone#: _____ Work Phone #: _____ Cell Phone #: _____

Referring Physician: _____ Phone #: _____ Fax #: _____

Contact Person: _____ Phone #: _____

Patient Insurance / Pre-Authorization :

Name of Insurance Company: _____

Pre-Authorization Needed: **Yes** _____ **No** _____ If Yes, pre-Authorization # is: _____

Contact Name: _____

If No Pre-Authorization Required, **Why?** _____

Contact Name: _____

Whole Body Pet Medicare Approved Indications		
Lung Cancer (non-small cell) Diagnosis		GO210
Lung Cancer (non-small cell) Initial Staging		GO211
Lung Cancer (non-small cell) Restaging		GO212
Breast Cancer Staging/Restaging		GO253
Breast Cancer Response to Treatment		GO254
Colorectal Cancer Diagnosis		GO213
Colorectal Cancer Initial Staging		GO214
Colorectal Cancer Restaging		GO215
Melanoma Diagnosis		GO216
Melanoma Initial Staging		GO217
Melanoma Restaging		GO218

Whole Body PET Medicare Approved Indications (cont.)		
Single Pulmonary Nodule Characterization		GO125
Lymphoma Diagnosis		GO220
Lymphoma Initial Staging		GO221
Lymphoma Restaging		GO222
Head and Neck Cancer Diagnosis		GO223
Head and Neck Cancer Initial Staging		GO224
Head and Neck Cancer Restaging		GO225
Esophageal Cancer Diagnosis		GO226
Esophageal Cancer Initial Staging		GO227
Esophageal Cancer Restaging		GO228
Thyroid Cancer Restaging		GO296

Other Medicare Approved Indications		
Refractory Seizures Pre-surgical evaluation		GO229
Myocardial Viability Following inconclusive SPECT		GO230
Myocardial Viability Primary or initial diagnostic study prior to revascularization		78459

Non Medicare PET Services		
PET Tumor Imaging Metabolic		78810
PET Myocardial Imaging Metabolic		78459
PET Brain Imaging Metabolic		78608

Patient History:

Pt Height: _____ Pt Weight: _____ Patient Pregnant or Breast Feeding: **Yes** **No**

Patient Diabetic: **Yes / No** If Yes, how is diabetes controlled?

Diet: _____ Insulin: _____ Oral Medication: _____

Patient Claustrophobic: **Yes / No**

Biopsies: If so, date and location of biopsy, result
Yes No

Any Recent Illnesses:
Yes No

Surgery: If so, date and location of surgery
Yes No

Any Recent Trauma:
Yes No

Radiation Therapy: If so, date of last treatment
Yes No

Any Previous CT, MRI, or PET Scans:

Yes No CT Date / Location: _____

Chemotherapy: If so, date of last treatment
Yes No

Yes No MRI Date / Location _____

Supporting Documentation Faxed: **Yes / No**

Yes No PET Date / Location: _____

- MeritCare order form
- CT, MRI, Biopsy Reports
- History and Physical (or most recent clinical notes or dictation)