

**Physician Order Form for PET/CT**

**DATE:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Primary Diagnosis:**

*(Signs/Symptom/Diagnosis: R/O is NOT acceptable as a Primary Diagnosis)*

**Clinical Question:** *(please specify; initial treatment strategy, subsequent treatment strategy)*

**Patient Cancer History:**

**PET Examination Requested:**

- 1) \_\_\_\_\_ Total Body PET/CT scan *(eyebrows to mid-thigh)*  
2) \_\_\_\_\_ Brain PET scan \_\_\_\_\_ Evaluate FTD vs. AD \_\_\_\_\_ Other  
3) \_\_\_\_\_ Cardiac PET scan *(evaluate viable cardiac tissue)*

Is the Patient in ChemoTherapy? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, when was the last treatment? \_\_\_\_\_

Is the Patient currently taking Neupogen or Neulasta? \_\_\_\_\_ Yes \_\_\_\_\_ No  
*(patient must be off medication four weeks prior to a PET scan)*

Is the Patient in Radiation Therapy? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, when was the last treatment? \_\_\_\_\_

**Signature of Referring Physician:** \_\_\_\_\_

Referring MD's office phone: \_\_\_\_\_ Fax: \_\_\_\_\_

PET scan Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

*(This requisition must be filled out entirely and accurately in order for the PET scan to be properly scheduled.) Please FAX this form to: 978-682-0984*



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