

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/CT Examination Requested:

- 1) _____ Total Body PET/CT scan *(eyebrows to mid-thigh)*
- 2) _____ Brain PET/CT scan ___ Evaluate FTD vs. AD ___ Other
- 3) _____ Cardiac PET/CT scan *(evaluate viable cardiac tissue)*
- 4) _____ ¹⁸F-Sodium Fluoride (NaF) PET/CT Bone Scan

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: 603-663-2379



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