

Physician Order Form for PET/CT

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

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

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

Primary Diagnosis:

*(Signs/Symptoms/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)

CT with Contrast Requested: \_\_\_ Neck \_\_\_ Chest \_\_\_ Abdomen \_\_\_ Pelvis  
*(a CT or attenuation correction only will be performed if you do not check one or all of the above)*

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 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 PET scan to be properly scheduled). Please FAX this form to: 978-682-0984*

