Physician Order Form for Nuclear Medicine Imaging

To schedule, FAX completed form to: 503-494-2879 Voice contact: 503-494-8468
*Required information is indicated in **BOLD**, this request will be returned unscheduled, if incomplete*

Patient Information

Patient Name: (Last, First) _____ DOB : / / Height: Weight:
OHSU Medical Record Number: _____ **Gender: ☐ M ☐ F Phone:**
Insurance Plan/FSC: _____Member Insurance #:

Physician and Order Information

Referring Physician Name: Signature:

☐ URGENT ☐ ROUTINE	**Phone Number: _____**
☐ Radiology to call patient to schedule exam	**Fax Number: _____**
NPI:_____	**Authorization Number: _____**
PIC:_____	**Authorization Dates: _____- _____**
Office Contact: _____	**Valid dates: _____ To_____**
ICD-10 Codes: **Diagnosis/Indications:**	**Prior PET/CT Exam: ☐Yes ☐No** **Pregnant: ☐ Yes ☐ No ☐ N/A**

Other prior imaging studies: (Check all that apply) ☐ CT ☐ MRI ☐ US ☐ None
Diabetic? ☐ Yes ☐ No Renal Disease: ☐ Yes ☐ No Claustrophobic ☐ Yes ☐ No
Results needed for next appointment? ☐ **Yes** ☐ **No** Requested Exam date:
If yes, Next appointment date: _____ Time:_____

PET (PET/CT is routinely used for Tumor Imaging of the body. This exam includes a low dose non-contrast CT scan.)

☐ Brain PET
- ☐ Seizure ☐ Tumor ☐ Dementia
- ☐ Other: _____

☐ Body FDG PET (Tumor)

Please identify primary cancer:
- ☐ Breast
- ☐ Cervical
- ☐ Colorectal
- ☐ Esophageal
- ☐ Head & Neck
- ☐ Lung Nodule
- ☐ Lung Cancer
- ☐ Lymphoma ☐CTCL ☐NHL
- ☐ Melanoma
- ☐ Multiple Myeloma
- ☐ Ovarian
- ☐ Other:_____

☐ Axumin PET for Prostate Ca

☐ NETSPOT PET for Neuroendocrine Ca

☐ Cardiac PET
- ☐ Sarcoid ☐ Viability
- ☐ Other: _____

Indication for PET Tumor Scan:
- ☐ Initial treatment strategy
- ☐ Subsequent treatment strategy

Other:_____

Include Diagnostic CT with IV contrast
- ☐ Neck CT with IV contrast
- ☐ Chest CT with IV contrast
- ☐ Abdomen CT with portal phase IV contrast
- ☐ Pelvis CT with portal phase IV contrast
- ☐ Other: _____

Indication for diagnostic CT Scan(s):

Additional clinical history and symptoms:

Physician Signature: _____(MD, DO, NP, PA) Date: _____
Scheduled date: Scheduled time: Preferred Location: ☐Main Campus ☐Beaverton