Physician Order Form for PET/CT

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 Name *(Last Name, First Name, MI):*

OHSU Medical Record Number: _____

Date of Birth: _____ ❑ **Male** ❑ **Female**

Weight: _____

Insurance Plan/FSC: _____

Member Insurance #: _____

Authorization #: _____

Valid dates: From _____ **To** _____

Required information needed to schedule:

Referring MD: _____

NPI #: _____ **PIC:** _____

Fax: _____ **Office Phone:** _____

Office contact: _____

Patient's Phone *(H/W/Cell)*: _____

Radiology to call patient to schedule exam? ❑ Yes ❑ No

ICD-10 Codes: _____

Diagnosis/Indications: _____

Prior PET/CT exam: ❑ Yes ❑ No Other Prior Imaging Studies (check all that apply): ❑ CT ❑ MRI ❑ US ❑ None

Pregnant: ❑ **Yes** ❑ **No** ❑ **N/A** **Diabetic** ❑ **Yes** ❑ **No** **Renal Disease** ❑ **Yes** ❑ **No** **Claustrophobic?** ❑ **Yes** ❑ **No**

Results needed for next appointment? ❑ Yes ❑ No **Requested Exam Date:** _____

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: _____ Time: _____

Scheduled Date: _____ Scheduled time: _____ AM / PM

Preferred Location: ❑ **Main Campus** ❑ **Beaverton**