New England

PET

Imaging System

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-NaF Sodium Fluoride PET 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: 978-458-9876

ACR RADIOLOGY ACCREDITED FACILITY

Accredited by the American College of Radiology

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