

**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) \_\_\_\_\_ <sup>18</sup>F-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: 978-682-0984*



Accredited by the  
American College  
of Radiology