

PET/CT REQUISITION FORM

Nuclear Medicine Department
(434) 982-7139
Fax (434) 244-5914

Please complete the following required information

PATIENT INFORMATION

Patient Name (Last, First, Middle)				Birthdate (Month/Day/Year)	
Sex	MRN	Weight	Phone # ()	Work Phone # ()	
Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No	PET Registry** <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient's Primary Insurance		Prior-authorization No. (if unapproved clinical)	

ORDER INFORMATION

Date of Order	Appointment Date	Appointment Time	Ordering Physician (Print)
Office Phone # ()	Office Fax # ()	Physician Signature	

Clinical Information (Reason for exam to include patient symptoms):

Please mark which of the following indications applies for the use of PET:

1. **Diagnosis** **Initial Staging** **Restaging** **Response to Therapy**
2. **PET, Lung** **PET, Esophageal** **PET, Lymphoma** **PET, Melanoma**
 PET, Colorectal **PET, Head & Neck** **PET, Heart** **PET, Brain**

Please Note: If exam is scheduled for reasons other than those listed above, a prior-authorization number must be obtained from the patient's insurance company.

PET Patient Information Questions

Comments

- | | | |
|--|--|-------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. Is the patient diabetic? | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Is the patient pregnant? | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. LMP? | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Is the patient breast-feeding? | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Currently undergoing chemotherapy?* | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Currently undergoing radiation?* | _____ |

*Patient must be off chemotherapy or radiation a minimum of 3 weeks prior to scan.

- | | | |
|--|--------------------------------------|-------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Recent surgery or biopsy? | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. Melanoma? (If yes, indicate site) | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Is the patient claustrophobic? | _____ |

OFFICE INSTRUCTIONS

- Call (434) 982-7139 (Department of Nuclear Medicine) to obtain appointment date and time.
- Fax a copy of the PET Requisition Form to (434) 244-5914. **Cancellations must be made 48 hours prior to appointment. The Isotope is ordered specifically for the patient and cannot be reused.**
- ** If participating in the NOPR (PET registry), please fax the required forms to (434) 244-5914. Please be aware that the following forms must be received by the listed deadlines for the scan to be eligible for the Registry:
Pre-PET - by midnight the day before the exam
Post-PET - within 30 days of PET scan
If you have any questions about the PET registry, contact the Nuclear Medicine department at (434) 982-7139.

PATIENT INSTRUCTIONS

1. The scan is done at the **Outpatient Care Center** at 595 Peter Jefferson Parkway. See map below.
2. **Low-carb diet** 24 hours prior. (**NO** sugar, pasta, bread, potatoes, rice, corn, carrots, fruit, fruit juice)
3. **No exercise** 24 hours prior to appointment.
4. **DO NOT** chew gum, eat mints, or cough drops prior to exam.
5. **Nothing to eat or drink 6 hours** prior to exam. You may take medications.
6. **If you are diabetic**, please inform scheduling technologist for special instructions.
7. You must arrive **at least 60 minutes prior** to exam.
8. You will be required to lie flat and still for 45-60 minutes.
9. If you have a porta-cath, it must be accessed **PRIOR** to your appointment.

Please do not hesitate to contact the Nuclear Medicine Department if you have any questions about your appointment, (434) 982-7139. Thank you!

