MT BAKER PET/CT

PET/CT Referral Form

2930 Squalicum Parkway, Ste. 201, Bellingham, WA 98225
Scheduling: **866.533.4296** | Fax: **866.533.4297**

PATIENT INFORMATION

[1] Patient Name _____ [2] Date of Birth _____ [3] Height _____ [4] Weight _____

[5] Patient Address _____ [6] Patient Telephone # _____ [7] Patient Mobile # _____

[8] Referring Provider _____ [9] Provider Telephone # _____ [10] Provider Fax# _____

[11] SIGNS AND SYMPTOMS (REQUIRED)

Type of cancer _____ ❑ Histologically Proven ❑ Suspected

CPT Codes _____
If provided a specific CPT code, please provide.

Please check Radiopharmaceutical

❑ FDG ❑ DETECTNET
❑ AXUMIN ❑ PYLARIFY
❑ CERIANNA

INSURANCE INFORMATION

[12] Primary Insurance _____ **[13] Subscribers Insurance ID #** _____

Secondary Insurance _____ **Insurance Prior Authorization #** _____

CMS/APPROPRIATE USE CRITERIA (FOR MEDICARE PART B PATIENTS ONLY)

NPI# _____ **Name of CDSM Consulted (software used)** _____

Determination Result (check one):
❑ 1) Adheres to ❑ 2) Does Not Adhere to ❑ 3) Not Applicable

[14] *(Check ONE and fill out corresponding section completely)*

Initial Treatment Strategy

❑ **Diagnosis:** Abnormal finding of _____
Based on _____

Check one

❑ To determine whether the patient is a candidate for an invasive diagnosis or therapeutic procedure;

❑ To determine the optimal anatomic location for an invasive procedure; or

❑ To determine the anatomic extent of the tumor when the treatment recommendations depend on the extent,

❑ **Initial Staging:** of confirmed newly diagnosed cancer

Check one

❑ To determine whether the patient is a candidate for an invasive diagnosis or therapeutic procedure;

❑ To determine the optimal anatomic location for an invasive procedure; or

❑ To determine the anatomic extent of the tumor when the treatment recommendations depend on the extent.

❑ **Other** (e.g., Alzheimer's Disease). Please list reason for scan here:

_____

Subsequent Treatment Strategy

❑ **Restaging:** (after the completion of treatment)

Check one

❑ Status post the completion of treatment for the purpose of detecting residual disease
Last date of treatment: _____
Type of treatment: _____

❑ Detecting suspected recurrence, or metastasis of previously treated cancer:
Site of suspected recurrence / metastasis: _____
Based on: _____

❑ Determine the extent of a known recurrence.
Confirmed by: _____

❑ PET/CT is being used to potentially replace one or more imaging studies that (1) is being utilized to determine extent of known recurrence of (2) provided insufficient information for the clinical management of the patient.

❑ **Monitoring Tumor Response:** During Treatment

Check one

❑ Chemotherapy ❑ Radiotherapy ❑ Other (specify): _____

_____

[15] PRESCREENING QUESTIONNAIRE

Pregnant: ❑ Y ❑ N
Diabetes: ❑ Y ❑ N

Prior Studies/Treatment

Previous:	❑ CT	❑ MRI	❑ PET/CT	Where: _____	When: _____
Pathology:	❑ Y	❑ N		Where: _____	When: _____
Radiation Therapy:	❑ Y	❑ N		Provider: _____	When: _____
Chemotherapy:	❑ Y	❑ N		Provider: _____	When: _____

[16] **Authorized Treating Provider's Signature:** (Stamps Not Accepted) _____ [17] **NPI #** _____ [18] **Date** _____

Services provided by
ALLIANCE HEALTHCARE | RADIOLOGY

Please FAX this form (and recent office notes, radiology reports and pathology reports) to Scheduling Department at 866.533.4296 after patient's examination has been scheduled.