Baptist Health South Florida

PET/CT IMAGING ORDERS

Please complete request form and fax to 786-533-9924. For STAT requests, or for more information, please call the Scheduling Call Center at 786-573-6001. (Doctors' offices only)

CHOOSE LOCATION

☐ First available location

☐ Baptist Hospital
8900 N. Kendall Dr.
786-596-3482

☐ Baptist Health Medical Plaza (Palmetto Bay)
8750 SW 144 St.
786-596-3838

☐ Miami Cancer Institute
8900 N. Kendall Drive
786-527-8110

☐ Baptist Health Diagnostic Imaging at Plantation
1228 South Pine Island Rd., Suite 120
Plantation, Florida 33324

Date: _____ Appt. Date: _____ Appt. Time: _____ Confirmation No.: _____

Patient Name: _____ Last four digits of SSN: ***XXX - XX -*** _____ Date of Birth: _____

Home Phone No: _____ Cell Phone No: _____

Referring Physician: _____ Phone No.: _____ Fax No: _____

Primary Insurance Name: _____ Benefits Phone No.: _____

Plan ID: _____ Group No.: _____ Authorization No.: _____

Secondary Insurance Name: _____ Benefits Phone No.: _____

Plan ID: _____ Group No.: _____ AUC Score: _____ Decision Support No.: _____

DIAGNOSIS: _____

TYPE OF PET/CT SCAN REQUESTED

ONCOLOGY

F-18 FDG

☐ Brain Tumors..... CPT 78814 ☐ Head and Neck Cancer..... CPT 78815 ☐ Esophageal..... CPT 78815 ☐ Lymphoma ..... CPT 78815
☐ Breast..... CPT 78815 ☐ Colorectal..... CPT 78815 ☐ Sarcoma ..... CPT 78816 ☐ Ovarian ..... CPT 78815
☐ Non Small Cell Lung Cancer (NSCLC) ..... CPT 78815 ☐ Melanoma ..... CPT 78816 ☐ Multiple Myeloma ..... CPT 78816

☐ Solitary Pulmonary Nodule..... CPT 78815 ☐ Other Cancer (Please specify): _____

PATIENT PREPARATION: No eating or drinking for 6 hours prior to the exam. This includes chewing gun, breath mints, cough drops and candy. Medications, including those to help alleviate pain, can be taken as usual with a small amount of water. If you are diabetic or taking insulin, call the PET department for further instructions. Avoid strenuous exercise for 24 hours prior to your appointment. Allow 3 - 4 hours for the exam.

☐ **PET-CT Neuroendocrine Tumor** .....CPT 78815

PATIENT PREPARATION: Patients may eat and drink prior to coming for the exam. **If the patient is on Somatostatin therapy, please indicate the date of last treatment: _____ .

☐ **PET-CT Prostate PSMA** ..... CPT 78815 **(must have 2 previous PSA results):** _____ _____

☐ **PET-CT Estrogen Receptor** ..... CPT 78815

Do not delay indicated therapy in order to administer Cerianna. Image patients with Cerianna prior to starting systemic endorine therapies that block ER.	
Recommendation: estimated time periods over which ER binding may reduce 18F-FES binding following administration of ER-targeted systemic endocrine therapies.	
Approximate duration in weeks that therapy may reduce Cerianna uptake.	
Therapy	**Duration**
ER modulator (e.g., tamoxifen, toremifene)	8 weeks
ER down-regulator (e.g., fulvestrant)	28 weeks

PATIENT PREPARATION: No preparation needed.

Please indicate the reason for requesting exam (required).

☐ Initial Treatment Strategy *Check appropriate box below (required)*
☐ Diagnosis ☐ Staging

☐ Subsequent Treatment Strategy *Check appropriate box below (required)*
☐ Restaging ☐ Monitor response to treatment

NEUROLOGY (BHM only)

☐ Brain for Alzheimer's or frontal-temporal dementia (FDG) ..... CPT 78608
***** Completion of Page 2 required for this exam***

☐ Brain for Alzheimer's (IDEAS – Amyvid) .....CPT 78814
☐ Refractory seizures .....CPT 78608

CARDIOLOGY (BHM only)

☐ Myocardial viability ..... CPT 78459

PATIENT HISTORY

Has patient had four or more PET scans same diagnosis? ..... ☐ No ☐ Yes

Allergy to Iodine: ..... ☐ No ☐ Yes

Diabetes: ..... ☐ No ☐ Yes ☐ Insulin ☐ Oral Meds

Pregnant or Breast feeding:..... ☐ No ☐ Yes

Cancer Treatment: ☐ Radiation Therapy ☐ Chemotherapy Date of Last Treatment: _____

Was a CT, MRI or PET scan performed in the last 12 months? .. ☐ No ☐ Yes Where? _____

Please fax report(s) with request.

_____ _____ _____ _____

Physician Name (print) ***Signature*** ***Date*** ***Time***

INSTRUCTIONS FOR PHYSICIANS

PET scans for Alzheimer's or frontal-temporal dementia

To be completed by referring physician's office.

Required documentation for Medicare coverage per National Coverage Determination (NCD)	
In order to support Medicare documentation requirements for FDG-PET Scan, the actual reports of the clinical data listed below must be in the patient's medical record at the facility prior to the exam being performed. Per Medicare NCD-The referring and billing provider(s) are required to have documented and established the medical necessity of an FDG PET scan by ensuring that the following information has been collected and is maintained in the beneficiary medical record:	
☐ YES ☐ NO	Date of onset of symptoms;
☐ YES ☐ NO	Diagnosis of clinical syndrome (normal aging; mild cognitive impairment (MCI); mild, moderate or severe dementia);
☐ YES ☐ NO	Mini mental status exam (MMSE) or similar test score;
☐ YES ☐ NO	Presumptive cause (possible, probable, uncertain AD);
☐ YES ☐ NO	Any neuropsychological testing performed;
☐ YES ☐ NO	Results of any structural imaging (MRI or CT) performed;
☐ YES ☐ NO	Relevant laboratory tests (B12, thyroid hormone); and,
☐ YES ☐ NO	Number and name of prescribed medications.

Physician Name (print)	*Signature*	*Date*	*Time*