MONTCLAIR RADIOLOGY
www.montclairradiology.com

PET/CT SCAN

79 HUDSON STREET, HOBOKEN, NJ 07030
TEL 201-222-2500 FAX 973-661-5245

Medicare AUC Mandate requires documentation of qCDSM: **HCPCS Modifier** (2 digits): _____ **G-Code** (5 digits): _____

Patient Name _____ Date of Order _____

Date of Birth ___/___/___ Mobile Phone _____ Home Phone _____

Referring Doctor _____ Phone _____

Address _____ Fax _____

Referring Provider's Signature X _____ PLEASE SIGN OR STAMP – STATE REQUIREMENT

Insurance _____ Authorization # _____

Reason for Exam _____

SYMPTOMS - CLINICAL INFO - REQUIRED BY INSURANCE CO. ❑ Chronic ❑ New Onset ❑ Follow-up ❑ Wet Reading - STAT

CLINICAL INDICATIONS:	CPT	Diagnosis/ Initial Staging	Monitoring/ Restaging/ Suspected Recurrence
NEUROLOGICAL:			
Cognitive Impairment/ Rule out Alzheimer's	78608	❑	See Patient Criteria
Brain Metabolism (Epilepsy)	78608	❑	N/A
Brain Amyloid Imaging	78608	❑	❑
ONCOLOGICAL:			
Breast			
F18-FDG	78815	❑	❑
Cerianna (FES estrogen receptor imaging)	78815	❑	❑
Cervical/ Ovarian/ Uterine	78815	❑	❑
Colorectal	78815	❑	❑
Esophageal	78815	❑	❑
Head & Neck (Non CNS/Non Thyroid)	78815	❑	❑
Lung	78815	❑	❑
Lymphoma	78815	❑	❑
Melanoma	78816	❑	❑
Prostate			
Axumin	78815	❑	❑
PSMA	78815	❑	❑
Solitary Pulmonary Nodule Characterization	78815	❑	N/A
Somatostatin receptor PET Imaging Detectnet™ (Cu64 Dotatate)	78815	❑	❑
Thyroid (Papillary)	78815	❑	❑
OTHER			
Specify:_____	_____	❑	❑

Please note that we participate with the National Oncological Pet Registry (N.O.P.R.) research program which provides coverage to Medicare patients for most PET/CT's being performed for non-covered indications. We will notify you and provide additional forms to be completed if required.

CLINICAL HISTORY:

Diabetic ❑ YES ❑ NO

Pregnant ❑ YES ❑ NO **Breast Feeding** ❑ YES ❑ NO

Type of Biopsy/Surgery & Date: _____

Is any Infection Present? ❑ YES ❑ NO

Organism/Location:_____

Radiation Therapy Last Date:_____
(PET/CT scan must be 2 months after Treatment)

Chemotherapy/Last Date:_____
(PET/CT scan must be between cycles)

Anatomic Location _____Name of Drug _____

Recent CT, MRI or PET Scan: ❑ YES ❑ NO
(If "Yes" fax reports with completed form)

Have you recently had an Upper GI Series, Small Bowel Series, or Barium Enema? ❑ YES ❑ NO if so, when?_____

ALZHEIMER'S PATIENT:
MEDICAL HISTORY AND PATIENT CRITERIA

Date of onset of clinical symptoms: _____/_____/_____

Diabetic: ❑ Yes ❑ No

EXAM REQUESTED

Brain PET/CT to differentiate Alzheimer's disease from Dementia (CDM code: 094033 81)

CERTIFICATION:

(IF PATIENT HAS MEDICARE AS PRIMARY INSURANCE, ALL MUST BE CHECKED)

❑ The patient has documented clinical cognitive decline over a 6 month period.

❑ Cognitive decline is not typical for Alzheimer's disease versus Frontal Temporal Dementia.

❑ The patient had comprehensive clinical evaluation performed by a physician experienced in the diagnosis and treatment of dementia.

❑ The patient has not had a PET Scan within the last 12 months.

CLINICAL FINDINGS:

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