Fax this request form to WDH Patient Access at (603) 740−2398

Last Name: _____ **First Name:** _____ **M.I.** _____

Sex: ❑ **M** ❑ **F** **DOB:** _____ **Diabetic:** ❑ **Y** ❑ **N**

Note: Patient's weight must NOT exceed 350lbs

Home Phone: _____ **Alternate Phone:** _____

Address: _____

Patient's Primary Care Physician Name: _____ **Telephone Number:** _____

Pre−Certification / Pre−Authorization Number: _____

Date of Last Chemotherapy or Radiation Therapy Treatment: _____

Ordering Clinician Office must fax the following accessory information to (603) 740−2650 in order to schedule a PET/CT Scan:

1. Most recent imaging report
2. Pathology report(s)
3. Current list of patient medications
4. Clinician progress notes

❑ **78814 (limited area)**

❍ Brain Tumor: initial treatment strategy only

❑ **78815 (skull base to mid−thigh)**

❍ Lip, Oral Cavity, and Pharynx Cancers: initial treatment and subsequent treatment strategy
❍ Esophageal Cancer: initial treatment and subsequent treatment strategy
❍ Stomach Cancer: initial treatment strategy only
❍ Small Intestine Cancer: initial treatment strategy only
❍ Colon, Rectum and Anal Cancer: initial treatment and subsequent treatment strategy
❍ Liver and Intrahepatic bile ducts: initial treatment strategy only
❍ Gallbladder & Extrahepatic bile ducts: initial treatment strategy only
❍ Pancreatic Cancer: initial treatment strategy only
❍ Retroperitoneum and peritoneum Cancer: initial treatment strategy only
❍ Nasal cavity, ear and sinuses: initial treatment and subsequent treatment strategy
❍ Larynx Cancer: initial treatment and subsequent treatment strategy
❍ Non Small Cell Lung Cancer: initial treatment and subsequent treatment strategy
❍ Pleural Cancer: initial treatment strategy only
❍ Thymus, Heart, Mediastinum Cancer: initial treatment strategy only
❍ Bone/Cartilage Cancer: initial treatment strategy only
❍ Connective/other Soft Tissue Cancers: initial treatment strategy only
❍ Breast Cancer: **PET not covered for diagnosis of breast masses or for axillary nodal staging − see footnotes 1 & 2.** Covered for initial treatment strategy only.
❍ Kaposi's Sarcoma: initial treatment strategy only
❍ Uterus Cancer: initial treatment strategy only
❍ Cervical Cancer: **PET not covered for diagnosis of cervical cancer − see footnote 3.** Covered for initial treatment and subsequent treatment strategy.
❍ Ovarian Cancer: initial treatment and subsequent treatment strategy
❍ Testicular Cancer: initial treatment strategy only
❍ Penis and other male genitalia: initial treatment strategy only
❍ Kidney and other urinary tract Cancer: initial treatment strategy only
❍ Eye (includes ocular melanoma): initial treatment strategy only
❍ Primary Brain Cancer: initial treatment strategy only
❍ Other and unspecified nervous system: initial treatment strategy only
❍ Metastatic cancer/unknown primary origin: initial treatment strategy only
❍ Lymphoma: initial treatment and subsequent treatment strategy
❍ Myeloma: initial treatment and subsequent treatment strategy
❍ Neuroendocrine tumor: initial treatment strategy only
❍ All other solid tumors: initial treatment strategy only

❑ **78816 (top of skull to toe)**

❍ Melanoma: initial treatment strategy or subsequent treatment strategy

NOTE: Nasopharyngeal, ocular and vulvar/vaginal melanomas are coded based on those anatomic locations; PET not covered for regional node staging − see footnote 1.

Footnotes:

1. PET is non−covered for initial staging for axillary lymph nodes in patients with breast cancer and of regional lymph nodes in patients with melanoma, but is covered for detection of distant metastatic disease in high−risk patients with breast cancer or melanoma.
2. PET is non−covered for diagnosis of breast cancer to evaluate a suspicious breast mass. However, PET is covered for initial treatment strategy evaluation of a patient with axillary nodal metastasis of unknown primary origin or in a patient with a paraneoplastic syndrome potentially caused by an occult breast cancer.
3. PET is non−covered for diagnosis of cervical cancer. However, PET is covered for initial staging of cervical cancer.
4. To qualify as a covered indication for subsequent treatment strategy evaluation, thyroid cancer must be of follicular cell origin and been previously treated by thyroidectomy and radioiodine ablation and the patient must have a serum thyroglobulin >10ng/ml and negative whole−body I−131 scan.

Diagnosis (Must be a Cancer Diagnosis): _____

Check one: ❑ **INITIAL TREATMENT STRATEGY** **OR** ❑ **SUBSEQUENT TREATMENT STRATEGY**

Ordering Clinician Signature (REQUIRED): _____ **Date/Time:** _____

Wentworth−Douglass Hospital

IMAGING SERVICES: P.E.T./CT SCHEDULING REQUEST

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