Your Hospital's Logo Here

PET/CT Procedure Referring
PHYSICIAN'S ORDER SHEET

ALL ORDERS WILL BE FULFILLED UNLESS CROSSED OUT
AFTER EACH ORDER IS PROPERLY CHECKED, FAX ORDER SHEET TO PHARMACY WHETHER OR NOT ORDERS INVOLVE MEDICATION.

Check (√) Each Order As Transcribed	Check (√) Pharmacy Orders	
		DATE: **TIME:** (Military Time)
		PATIENT: *Last* *First* *MI* DOB:
		MED REC #: ACCOUNT #:
		Allergy
		1. Diagnostic Information: medical necessity for procedure(s) requested. Describe patient's signs, symptoms & physical findings that you believe indicate a need for the procedure(s) you are ordering below. Payers generally do not consider a [1] question, [2] suspect, or [3] rule out diagnosis, in an of itself, to be acceptable as "diagnostic information."

PROCEDURE Description, Site	Limited Site PET/CT	Skull to Thigh PET/CT	Entire Body PET/CT	DIAG.	PET Registry Monitoring	Init'l Staging	Re Staging
PET Colorectal	☐ 78814	☐ 78815	☐ 78816	☐	☐	☐	☐
PET Esophageal	☐ 78814	☐ 78815	☐ 78816	☐	☐	☐	☐
PET Head&Neck (excl. thyroid)	☐ 78814	☐ 78815	☐ 78816	☐	☐	☐	☐
PET Lung (non small cell)	☐ 78814	☐ 78815	☐ 78816	☐	☐	☐	☐
PET Lymphoma	☐ 78814	☐ 78815	☐ 78816	☐	☐	☐	☐
PET Melanoma	☐ 78814	☐ 78815	☐ 78816	☐	☐	☐	☐
PET Thyroid	☐ 78814	☐ 78815	☐ 78816	N / A	☐	N / A	☐
PET Breast	☐ 78814	☐ 78815	☐ 78816	N / A	☐	☐	☐
PET Single Pulmonary Nodule	☐ 78814	☐ 78815	☐ 78816	CHARACTERIZATION ONLY			
PET Cervical	☐ 78814	☐ 78815	☐ 78816	☐	☐	☐	☐

		2. Suspected or questioned condition to rule out (optional):
		3. Related Information for Screening of Medical Necessity (see criteria):
Insurance Company: Pre-Auth # _____		
FAXED BY/TIME:	**TIME NOTED:**	Doctor's Signature _____,MD Date _____ Staff Member obtaining Insurance Pre-authorization Signature / Title_____ Date _____
Military Time > >		

USE BALL POINT PEN ONLY - PRESS FIRMLY

PART OF THE MEDICAL RECORD