RADIOLOGY CORPORATION OF AMERICA

Westside Regional Medical Center

8201 West Broward Boulevard
Plantation, FL 33324
Scheduling Phone: 954-370-4450

PET/CT Imaging Request Form

Patient's Name_____ **Date of Birth** ____/____/____ **Exam Date** ____/____/____

Home Phone_____ **Work Phone**_____ **Weight** _____ **Height**_____**Gender**____

Referring Physician_____**Phone**_____**Fax** _____

STAT REPORT NEEDED: ☐ **Yes** ☐ **No** **PHONE RESULTS:** ☐ **Yes** ☐ **No** **FAX RESULTS:** ☐ **Yes** ☐ **No**

Copy to Additional Physician_____**Phone**_____**Fax**_____

(1) Please select the PET/CT requested: ☐ **Limited Area** ☐ **Skull base to Mid-thigh** ☐ **Whole Body**

(Standard Exam) **(Melanoma Exam)**

(2) Diagnosis/ICD-9 Code: _____

(3) Please select the indication below:

☐ **Solitary Pulmonary Nodule** (indeterminate nodule less than 4 cm)

Lung Cancer, non-small cell
☐ Diagnosis
☐ Initial Staging
☐ Restaging

Colorectal Cancer
☐ Diagnosis
☐ Initial Staging
☐ Restaging

Breast Cancer
☐ Diagnosis
(Procedure not covered by Medicare)
☐ Staging or Restaging
☐ Monitor therapy for possible change in treatment

Cervical Cancer
☐ Initial Staging (limitations apply)

Head & Neck Cancer
☐ Diagnosis
☐ Initial Staging
☐ Restaging

Esophageal Cancer
☐ Diagnosis
☐ Initial Staging
☐ Restaging

Thyroid Cancer
☐ Restaging

Melanoma
☐ Diagnosis
☐ Initial Staging
☐ Restaging

Lymphoma
☐ Diagnosis
☐ Initial Staging
☐ Restaging

☐ **Non-Medicare Indication:**
_____
Please specify

Patient History:

Diabetes: ☐ Yes ☐No **How is it controlled?** ☐ Oral Meds ☐ Insulin ☐ Other _____

Surgery/Biopsy: ☐ Yes ☐ No Type of Surgery and Date:_____ _____/_____/____

Relevant History:_____ Any infection present? ☐ Yes ☐ No

Was a CT, MRI or PET/CT scan done on patient in last 12 months? If yes, please include date and location (fax copy of report) :

_____ _____/_____/_____

Pregnant or Breastfeeding: ☐ Yes ☐No

Radiation Therapy (RT) ☐ Yes ☐ No
Anatomic Location: _____
Date of Completion: _____/_____/_____

Chemotherapy ☐ Yes ☐ NO
Name of drug: _____
Date of Completion: _____/_____/_____

Physician Signature: _____

Please sign and fax this form to the Scheduling Department at 954-476-3974