

# PET MEDICAL IMAGING CENTER

Spectrum Health · Saint Mary's Health Care  
Advanced Radiology Services, PC · Kent Radiology, PC

## POSITRON EMISSION TOMOGRAPHY (PET) - COMPUTED TOMOGRAPHY (CT) ORDER/SCHEDULING AND HISTORY FORM

Scheduling Phone (616) 391-6001      Scheduling Fax (616) 391-6018      PET-CT Tech Line (616) 391-6006

**PATIENT INFORMATION** (Please Print)      Date Exam Needed: \_\_\_\_\_

Patient's Name (Last, First & Middle): \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_      Patient's Weight: \_\_\_\_\_ lb      Height: \_\_\_\_\_

**MUST HAVE WEIGHT TO SCHEDULE APPT. WEIGHT LIMIT 450 lbs**

Patient's Contact Phone # 's: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Ordering Physician Name: \_\_\_\_\_ Contact person in office: \_\_\_\_\_

Ordering Physician's office phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Patient's Primary Care Physician (PCP is Required please): \_\_\_\_\_

**SPECIFIC EXAMS REQUESTED:** \_\_\_\_\_ **CPT**

PET-CT SCAN: \_\_\_\_\_

**AND**

CT-INTERPRETATION: \_\_\_\_\_

REASON FOR EXAMS: (please print) \_\_\_\_\_ **ICD-9 CODE:** \_\_\_\_\_

MEDICAL NECESSITY FOR EXAMS: (CLINICAL HISTORY, PATHOLOGY, LABORATORY, X-RAY REPORTS):  
\_\_\_\_\_  
\_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**\*\*\*SIGNATURE NOT REQUIRED UNTIL EXAM HAS BEEN REVIEWED BY PET/CT RADIOLOGIST**

### **PATIENT HISTORY - QUESTIONS MUST BE ANSWERED FOR US TO SCHEDULE YOUR PATIENT.**

Is Patient Claustrophobic?       Yes       No  
Previous Surgery?       Yes       No      If yes, When? Date: \_\_\_\_\_  
Is Patient a Diabetic?       Yes       No      If yes, does the patient take Insulin? Yes  No   
Latex Allergy?       Yes       No  
Contrast Allergy?       Yes       No  
Most recent Creatinine level results: \_\_\_\_\_ mg/dL  
Does Patient have a HX of cancer?       Yes       No      If yes, Primary site: \_\_\_\_\_  
Previous Radiation Therapy?       Yes       No      If yes, state date of last treatment: \_\_\_\_\_  
Previous Chemotherapy?       Yes       No      If yes, state date of last treatment: \_\_\_\_\_  
History of Neupogen Therapy?       Yes       No      If yes, state date of last treatment: \_\_\_\_\_  
History of Neulasta Therapy?       Yes       No      If yes, state date of last treatment: \_\_\_\_\_  
History of Procrit/Aransep?       Yes       No      If yes, state date of last treatment: \_\_\_\_\_  
Previous CT or MRI?       Yes       No      If yes, when? Date: \_\_\_\_\_ Where? \_\_\_\_\_  
Previous PET?       Yes       No      If yes, when? Date: \_\_\_\_\_  
Is patient pregnant or breast-feeding?       Yes       No  
Patient with special needs?       Yes       No  
Does patient need an interpreter?       Yes       No      If yes, what language \_\_\_\_\_

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## PET-CT INSURANCE VERIFICATION FORM

Scheduling Phone (616) 391-6001

Scheduling Fax (616) 391-6018

PET-CT Tech Line (616) 391-6006

Patient's Name (Last, First & Middle): \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient's Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_

### **INSURANCE INFORMATION**

#### **\*\*\*IF AVAILABLE PLEASE FAX PATIENT'S INSURANCE CARDS (FRONT & BACK)**

If copy of Insurance Cards Not Available (PLEASE PRINT) \*All information is needed for verification of benefits

**Primary Insurance Carrier:** \_\_\_\_\_

Name on Policy: \_\_\_\_\_

Policy Holders Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holders Date of Birth: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Plan Code: \_\_\_\_\_

**Secondary Insurance Carrier:** \_\_\_\_\_

Name on Policy: \_\_\_\_\_

Policy Holders Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holders Date of Birth: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Plan Code: \_\_\_\_\_

#### ***For Primary Insurance's:***

***Does the patient's Primary Insurance need Pre- Authorization? If yes, has it been requested? This is especially important for BCBS PPO, Priority Health, Medicaid Priority Health, Molina, Community Choice and all other HMO's. It is the ordering physician's office responsibility to obtain all insurance pre-authorizations prior to scheduling a PET-CT scan.***

YES If yes, Authorization Number Please (if available) \_\_\_\_\_

NO If no, **must** have prior approval before scheduling appointment. Call scheduling with authorization number when received.

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