

PET MEDICAL IMAGING CENTER

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

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:

PET-CT SCAN: _____ CPT Code: _____

AND

CT-INTERPRETATION: _____ CPT Code: _____

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 IMAGING RADIOLOGIST**

PATIENT HISTORY - QUESTIONS MUST BE ANSWERED TO ASSIST US IN SCHEDULING YOUR PATIENT.

Is Patient Claustrophobic?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Previous Surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, When? Date: _____
Does Patient have a "Power Port" ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is Patient a Diabetic?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, does the patient take Insulin ¹ Yes ¹ No
Latex Allergy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Contrast Allergy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Most recent Creatinine level results:	_____	_____	mg/dL
Does Patient have a HX of cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, Primary site: _____
Previous Radiation Therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, state date of last treatment: _____
Previous Chemotherapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, state date of last treatment: _____
History of Neupogen Therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, state date of last treatment: _____
History of Neulasta Therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, state date of last treatment: _____
History of Procrit/Aransep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, state date of last treatment: _____
Previous CT or MRI?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when? Date: _____ Where? _____
Previous PET?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when? Date: _____ When? _____
Is patient pregnant or breast-feeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Patient with special needs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does patient need an interpreter?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, what language

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Updated 10/30/2008

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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. Especially 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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