National PET Scan Dade, L.L.C.

7867 North Kendall Drive
Suite 121 Miami, FL 33156

: 305 455 3000
: 305 455 2065

PATIENT REFERRAL FORM

Patient Information

Patient Name: _____ Male ☐ Female ☐ Date of Birth: ___/___/_____

SSN: _____-___-_____ Home: _____ Cell: _____ Exam Date: ___/___/_____

Referring Physician Information

Physician Name: _____ Tel: _____ Contact: _____

Insurance Information

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

☐ Insurance Authorization Form and/or Authorization Number: _____

Please Provide the Following Information

☐ Patient Referral / Prescription (this form)

☐ Patient Reports / Records: ☐ CT ☐ MRI ☐ Pathology ☐ PET/CT Scan

PET/CT Scan Orders

PET/CT CPT CODES:

☐ 78815 PET/CT Tumor Imaging, Skull Base to Mid Thigh

☐ 78816 PET/CT Tumor Imaging, Whole Body

☐ 78608 PET/CT Scan Brain, Metabolic Evaluation

☐ F18-FDG ☐ F18-NaF Bone ☐ Ga68-Dotate

☐ Ga68-PSMA ☐ F18-PSMA

CT

	With / Without		With / Without
Head/Brain	☐ ☐	Pelvis	☐ ☐
Neck	☐ ☐	Abdomen/Pelvis	☐ ☐
Chest	☐ ☐	Abdomen	☐ ☐

☐ CPT Code: _____

INDICATION:

☐ Diagnosis ☐ Initial Staging ☐ Restaging ☐ Monitor Course of Therapy

ICD-10 / Diagnosis: _____

Physician Signature: _____ Date: ___/___/_____

PET CT ACR American College of Radiology Accredited Facility

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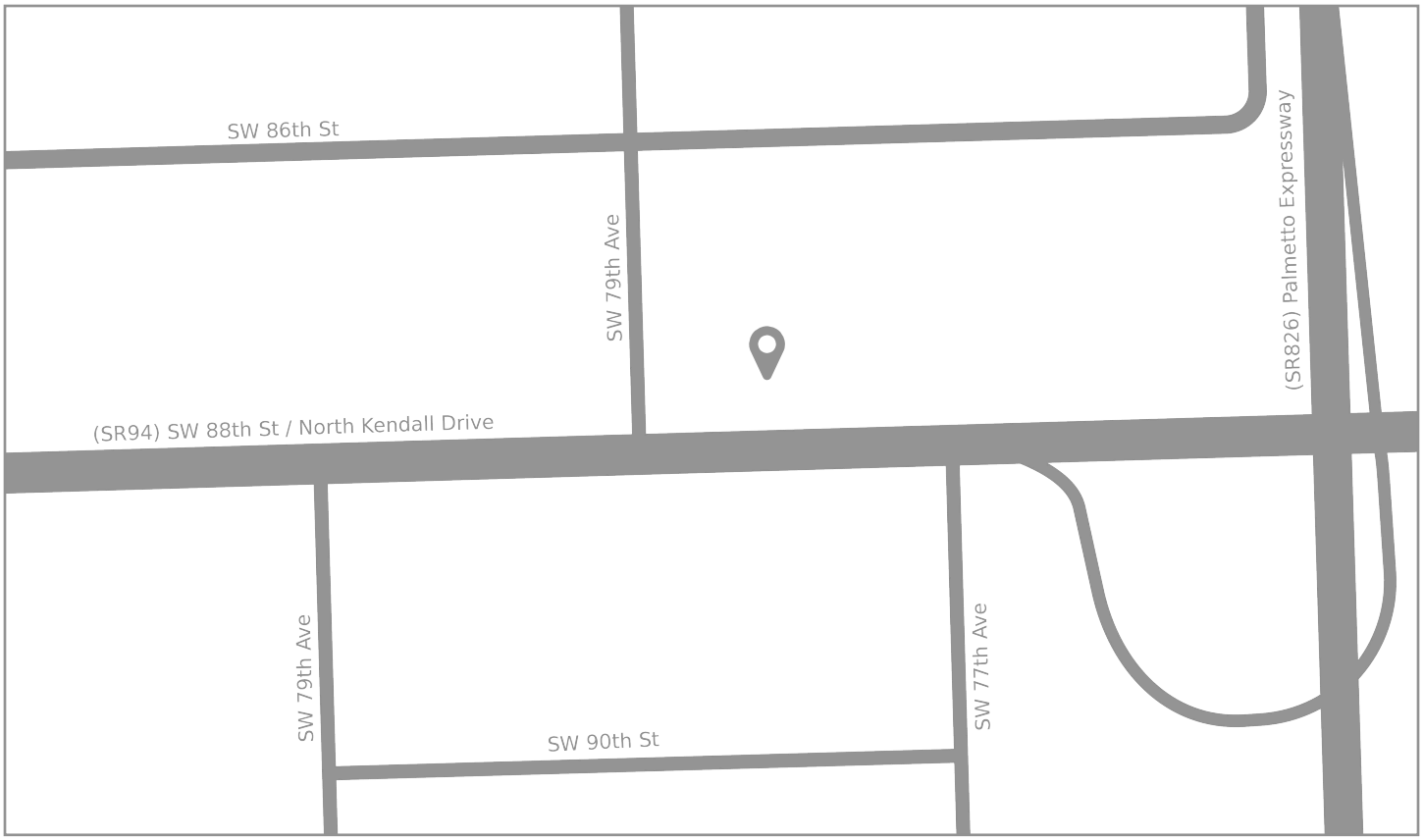

DO

- bring most recent CT or MRI films and reports
- plan to be at center for approximately two (2) hours
- wear comfortable clothing
- take prescribed medications, except INSULIN

DON'T

- eat for at least five (5) hours before the scan - water is okay

DIABETICS

PLEASE CALL 24 HOURS PRIOR TO YOUR APPOINTMENT FOR FURTHER INSTRUCTIONS.