

# The Radiology Clinic PET Scan Request Form

Complete this form and fax with request items to (205) 343- 0935  
For help question, please call (205) 345-7000 ext. 276

Patient \_\_\_\_\_ DOB \_\_\_\_\_

SS# \_\_\_\_\_ Sex \_\_\_\_\_ Hgt. \_\_\_\_\_ Wgt. \_\_\_\_\_ Diabetic: Y / N

Telephone (home) \_\_\_\_\_ Alternate \_\_\_\_\_

Primay Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

**Please include the following information and fax to the number above:**

**Copies of reports form the most current CT/MRI scans, biopsy results, and lab work.**

**Patient/Doctors notes**

**Clinical indication and ICD-0 codes marked on this sheet**

*Please enter ICD-9 Code*

*Please Check One*

<b>ICD - 9</b>	<b>Indication</b>	<b>Characterization</b>		
	Single Pulmonary nodule(not exceeding 4cm)			
<b>ICD-9</b>	<b>Indication</b>	<b>Diagnosis</b>	<b>Initial Staging</b>	<b>Restaging</b>
	Lung Ca			
	Melanoma			
	Lymphoma			
	Head and Neck (excluding CNS)			
	Esophageal Ca			
	Colorectal Ca			
	Breast Ca			
	Thyroid Ca			
	Evaluation of refractory seizures			
	Myocardial Viability			
	Other(specify)			

## DECLARATION OF MEDICAL NECESSITY

I \_\_\_\_\_ attest to the accuracy of the information and  
(print Physician's name) medical necessity of the exam ordered.

Physician's

Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_