



In affiliation with UPMC Cancer Centers

Na F18 Bone PET Scan - Scheduling Request

Check In Time: _____

Date of Service: _____

Please FAX form to: (814) 836-2648

Phone: (814) 836-2642

Today's Date: _____

Patient Name: _____

Address: _____

RCC #: _____

Social Security #: _____

DOB: _____

Phone: _____

Procedure:

Whole Body PET Bone Scan (head through toes – CT for attenuation correction only) #78816

Diagnosis: _____

ICD-9 Code: _____

Scheduling Comments: _____

Reason for PET Bone (please check one):

- Diagnosis of suspected osseous metastatic disease *in a patient without a pathologically proven diagnosis of cancer*
- Initial staging of newly diagnosed cancer
- Suspected **new** osseous metastasis as a site of recurrence or progression
- Suspected progression of known osseous metastasis
- Monitoring Treatment Response

Symptoms, Signs, or Other Findings Prompting F-18 Fluoride PET Bone Imaging (Check all that apply)

- Other: _____
- Skeletal pain
- New focal neurologic signs or symptoms
- Findings on other imaging studies suggesting osseous metastatic disease
- Hypercalcemia
- Elevated or increasing tumor marker(s) (including alkaline phosphatase)
- Evidence of new metastases in non-osseous sites
- Evidence of progression of known metastatic disease in non-osseous sites

Cancer Type – check the one pathologically proven or strongly suspected cancer type that most closely relates to the specific reason for the PET study indicated in response to Question 1. (Check only one):

- Lung
- Female Breast
- Other: _____
- Prostate
- Metastatic cancer of unknown primary origin

INSURANCE INFORMATION

Primary Insurance: _____

ID #: _____

Group#: _____

Secondary Insurance: _____

ID #: _____

Group #: _____

Rep Name: _____

If no auth required, name of person spoken to: _____

FAX all of the following information with scheduling request:

- Most recent imaging report
- Pathology report
- Tumor Marker Labs
- Physician progress note (need only if proving medical necessity)

MD Name (print): _____

Office Phone: _____

MD Signature: _____

Office Contact: _____