New England Molecular Imaging, L.L.C.

To schedule a patient please call (866) 245-5995
Fax this form to the Scheduling Dept. at (800) 508-1064

Please identify location for PET/CT to be completed:

❑ **Mercy Hospital** – 175 Fore River Parkway, Portland
❑ **York Hospital** – Wells Walk In Care, 114 Sanford Road, Wells

PATIENT INFORMATION

[1] Patient Name _____ [2] Date of Birth _____ [3] Height _____ [4] Weight _____

[5] Patient Address _____ [6] Patient Telephone # _____ [7] Patient Mobile # _____

[8] Referring Provider _____ [10] Provider Telephone # _____ [11] Provider Fax# _____

[12] SIGNS AND SYMPTOMS (REQUIRED)

Type of cancer _____ ❑ Histologically Proven ❑ Suspected

CPT Codes
If provided a specific CPT code, please provide. _____

INSURANCE INFORMATION

[13] Primary Insurance _____ [14] Subscribers Insurance ID # _____

Secondary Insurance _____ Insurance Prior Authorization **#** _____

[15] ***(Check ONE and fill out corresponding section completely)***

Initial Treatment Strategy

❑ **Diagnosis:** Abnormal finding of _____
Based on _____

Check one

❑ To determine whether the patient is a candidate for an invasive diagnosis or therapeutic procedure;

❑ To determine the optimal anatomic location for an invasive procedure; or

❑ To determine the anatomic extent of the tumor when the treatment recommendations depend on the extent,

❑ **Initial Staging:** of confirmed newly diagnosed cancer

Check one

❑ To determine whether the patient is a candidate for an invasive diagnosis or therapeutic procedure;

❑ To determine the optimal anatomic location for an invasive procedure; or

❑ To determine the anatomic extent of the tumor when the treatment recommendations depend on the extent.

❑ **Other** (e.g., Alzheimer's Disease). Please list reason for scan here:
_____

Subsequent Treatment Strategy

❑ **Restaging:** (after the completion of treatment)

Check one

❑ Status post the completion of treatment for the purpose of detecting residual disease
Last date of treatment: _____
Type of treatment: _____

❑ Detecting suspected recurrence, or metastasis of previously treated cancer:
Site of suspected recurrence / metastasis: _____
Based on: _____

❑ Determine the extend of a known recurrence.
Confirmed by: _____

❑ PET/CT is being used to potentially replace one or more imaging studies that (1) is being utilized to determine extent of known recurrence of (2) provided insufficient information for the clinical management of the patient.

❑ **Monitoring Tumor Response:** During Treatment

Check one

❑ Chemotherapy ❑ Radiotherapy ❑ Other (specify): _____
_____

[16] PRESCREENING QUESTIONNAIRE

Pregnant: ❑ Y ❑ N
Diabetes: ❑ Y ❑ N

Prior Studies/Treatment

Previous:	❑ CT	❑ MRI	❑ PET/CT	Where: _____	When: _____
Pathology:	❑ Y	❑ N		Where: _____	When: _____
Radiation Therapy:	❑ Y	❑ N		Physician: _____	When: _____
Chemotherapy:	❑ Y	❑ N		Physician: _____	When: _____

[17] **Authorized Treating Provider's Signature:** (Stamps Not Accepted) _____ [18] **NPI #** _____ [19] **Date** _____

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ALLIANCE HEALTHCARE | RADIOLOGY

Please FAX this form (and recent office notes, radiology reports and pathology reports) to Scheduling Department after patient's examination has been scheduled.