Mallinckrodt Institute of Radiology - Barnes-Jewish Hospital
Physician Request Form for F-18 Fluoride Bone PET/CT Imaging

Patient Name ______________________________ Date of Study ________________

DOB __________ Social Security No. ______________ Gender _____ Weight _____ lbs

Patient's Address ____

City, State, Zip ____________________ Patient's Phone ____________________

Physician ____________________ Physician's Phone/Pager ____________________

Type of Insurance: ____________________ Precert. # (if applicable) ____________________

Previous CT or MRI? ____________________ Where? ______________ Date? __________

Previous PET Study? ____________________ Where? ______________ Date? __________

Previous bone scan? ____________________ Where? ______________ Date? __________

STUDY REQUESTED (Check One)

- ❑ Standard body study (vertex to mid calf)
- ❑ Limited study (e.g., lumbar spine only)
- ❑ Whole-body study (vertex to toes)
  For known or suspected lower extremity disease distal to mid calf

SPECIFIC REASON FOR PET STUDY

ONCOLOGIC INDICATION

Type of Cancer______________________________ ❑ **Histologically Proven** ❑ **Suspected**

- ❑ **Diagnosis** of suspected osseous metastatic disease without a pathologically diagnosed cancer
- ❑ **Initial Staging** of confirmed, newly diagnosed cancer
- ❑ **Monitoring Response** during treatment
  ______Chemotherapy ______Radiotherapy
  ______Other (type)____________________
- ❑ **Restaging** after completion of therapy
  ______Chemotherapy ______Radiotherapy
  ______Other (type)____________________
- ❑ **Suspected Recurrence or Progression** of a previously treated cancer: Site of suspected recurrence or progression is
  ____
  based on ______________________
- ❑ **Surveillance** of a previously treated cancer in a patient with no known residual disease *(Not covered by most insurers)*

NON-ONCOLOGIC INDICATION

Specify reason for study:

Additional History or Instructions: ____

____

Physician Signature ____

For scheduling, please call 362-4PET (362-4738) or 888-362-4PET (888-362-4738)
Please FAX this form (and recent office notes, radiology reports and pathology reports) to 362-1032 after patient's examination has been scheduled.

SECOND PAGE MUST BE COMPLETED FOR MEDICARE PATIENTS

Check for current form and patient brochure at: http://gamma.wustl.edu/division/clinical-information.html

1-November-2012

ADDITIONAL INFORMATION REQUIRED IF MEDICARE IS PATIENT'S PRIMARY INSURANCE

Oncologic F-18 Fluoride Bone PET/CT studies are covered by Medicare only if the referring physician provides additional information before and after the PET study as part of the National Oncologic PET Registry (NOPR) (see http://www.cancerPETregistry.org).

If you have any questions regarding the validity of a referral, contact our physicians directly at (314) 362-4PET (362-4738) or (888) 362-4PET.

Please check the appropriate indication for the requested registry-covered indication:

- ☐ **NOPR Initial Staging,**
- ☐ **NOPR Restaging**
- ☐ **NOPR Monitoring Response to Therapy**
- ☐ **NOPR Suspected Recurrence or Progression**

[Note that PET for routine surveillance is not covered by Medicare and also that Medicare does not cover F-18 fluoride bone PET/CT done for non-oncologic indications.]

REQUIRED FOR NOPR STUDIES **Ethnicity:** ☐ Hispanic ☐ Not Hispanic ☐ Unknown

Race: ☐ Asian ☐ Black or African American ☐ White or Caucasian ☐ Other ☐ Unknown

For NOPR studies, also complete and submit the pre-PET form for National Oncologic PET Registry
http://www.cancerpetregistry.org/pdf/NOPR_NaF-18_Pre-PET_Form_2012.pdf

Physician Signature ________________________________ Date: ____________________
(A ***physician's*** signature is required)

Patient Name ____________________________________ DOB: ____________________

SECOND PAGE MUST BE COMPLETED FOR MEDICARE PATIENTS