Mallinckrodt Institute of Radiology - Barnes-Jewish Hospital
Physician Request Form for Brain Amyloid PET Imaging

Patient Name ______________________________ Birthdate ______________________________

Social Security No. ______________________________ Gender ______________________________

Address ____

City, State, Zip ________________________ Physician ______________________________

Patient's Phone ________________________ Physician's Phone/Pager ______________________

Date of Study ________________________ Type of Insurance: ______________________

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

Previous PET Study? ____________________ Where? ________________ Date? __________

Medicare currently reimburses for brain amyloid PET ONLY for patients enrolled in the IDEAS Study.

☐ ***Check if patient is enrolled in the IDEAS Study. Complete page 1 and sign on page 2. It is not necessary to complete page 2.***

Most other third-party payers currently do NOT reimburse for brain amyloid PET imaging. Thus, a patient referred for brain amyloid PET who is not enrolled in the IDEAS Study will be required to sign a financial responsibility form indicating that the patient understands that his/her insurer likely will not cover the study and that he/she will be personally responsible for charges from both Barnes-Jewish Hospital and Mallinckrodt Institute of Radiology (total self-pay cost of $4,400). Please explain this to your patient before referring for the study; we also will provide you with a copy of the financial responsibility form that may be given to the patient to review before the appointment. Because of the high cost of F-18 florbetapir, it is essential that scheduled patients do not decide to opt out of the test when they arrive at the PET facility.

For questions, please contact our physicians directly at 314-362-4PET (314-362-4738) or 888-362-4PET.

Please provide ALL of the following information ***(and send copies of relevant records)*****:**

Year of symptom onset: ______________________________

Clinical Dementia Rating (CDR), if available: ______________________

MiniMental State Examination (MMSE) score, if available: ____________

Neuropsychological testing results, if available (please summarize): ______________________

____

Severity of cognitive impairment (check appropriate box):

Dementia: ☐ Very Mild ☐ Mild ☐ Moderate

☐ Mild cognitive impairment

☐ Other (specify) ______________________________

Presumptive cause: ☐ Uncertain AD ☐ Possible AD ☐ Other (specify) ______________

Results of CT or MRI (summarize or send a copy of report) ______________________

____

If available, provide CD of recent brain imaging studies performed at outside facilities to allow for direct comparison with the amyloid PET images.

<u>**Please complete and sign page 2 of this form:**</u>

Physician Request Form for Brain Amyloid PET Imaging (Page 2)

Patient Name ____ DOB: ____
____

Please initial each of the following *[You may skip this section if patient is enrolled in the IDEAS Study]*:

I personally attest to the following and confirm that I have documentation to support the following:

Initials

☐ The patient has cognitive decline for at least 6 months as documented by a combination of (1) history-taking from the patient and a knowledgeable informant and (2) an objective cognitive assessment, either a "bedside" mental status examination or neuropsychological testing.

☐ The cognitive impairment represents a decline from previous levels of functioning for the patient, and is not explained by delirium or by major psychiatric disorder.

☐ The patient evaluation did not clearly determine a specific neurodegenerative disease or other cause for the cognitive decline, and information available through PET amyloid imaging is reasonably expected to help clarify the diagnosis and help guide future treatment.

☐ The patient has been evaluated by a physician experienced in the diagnosis and assessment of dementia.

Physician Signature ______________________________ Date ______________

(A ***physician's*** signature is required)

For scheduling, please call 314-362-4PET (314-362-4738) or 888-362-4PET (888-362-4738).

Please FAX this form (and relevant records, as indicated above) to 314-362-1032 after patient's examination has been scheduled.