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 and most other third-party payers currently DO NOT reimburse for brain amyloid PET imaging. Patients referred for brain amyloid PET will be required to contact financial services so 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. Please explain this to your patient before referring for the study. 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 call 314-362-4PET (314-362-4738) or 888-362-4PET (888-362-4738)

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:

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 _____

(***Physician's*** signature required)

Please FAX this form (and recent office notes, radiology reports, and pathology reports if not available in BJH/WU electronic records) to 314-362-1032 before calling to schedule the patient.

To schedule, please call 314-362-4PET (314-362-4738) or 888-362-4PET (888-362-4738).