Mallinckrodt Institute of Radiology - Barnes-Jewish Hospital

Physician Request Form for Brain FDG-PET/MRI

Patient Name _____ **Requested Date of Study** _____
Birthdate _____ **Gender** _____ **Weight** _____ **lbs**
Patient Address _____ **City, State, Zip** _____
Patient's Phone (Home) _____ **Alternate Number** _____
Physician _____ **Physician's Phone/Pager** _____
Type of Insurance _____ **Precert # (if applicable)** _____
Previous PET OR MRI Study Date _____ **Outside Study?** _____ **Images in LILA?** _____
Diabetic No ☐ **Yes** ☐ **Diabetic Medications** _____

Does the patient have brain aneurysm clip? ☐ **Yes** ☐ **No** **Does the patient have a pacemaker?** ☐ **Yes** ☐ **No**
Does the patient have a cochlear or stapes implant? ☐ **Yes** ☐ **No** **Does the patient have a defibrillator?** ☐ **Yes** ☐ **No**
Does the patient have injury to the eye involving metal or metal shavings? ☐ **Yes** ☐ **No**

Medicare will only reimburse for brain PET studies performed for certain specific clinical indications. Thus, for Medicare patients, it is important to ensure that your referral qualifies for reimbursement according to the specific criteria detailed below. If you have any questions regarding the validity of a referral, contact our physicians directly at 314-362-4PET (314-362-4738) or 888-362-4PET.

SPECIFIC REASON FOR BRAIN PET/MRI STUDY (Check One)

☐ **Brain Tumor (Covered by Medicare)**
☐ **Intractable seizure being evaluated for possible surgery (Covered by Medicare)**
☐ **Dementia (Possibly covered by Medicare; must complete pages 2 and 3 for Medicare patient)**
☐ **Other (Noncovered by Medicare)** _____

DEDICATED MRI STUDY REQUESTED (MUST CHECK at Least One)

Contrast ☐ **Without (70551)** ☐ **With and Without (70553)**

INSTRUCTIONS FOR PHYSICIAN'S OFFICE AND PATIENT FOR Brain PET/MRI

- **Outside studies for comparison should be uploaded to LILA and nominated as reference images**
- **Low carbohydrate diet on day before study**
- **No food after 7:00 a.m. if study time is after 1:00 p.m. (patient may eat a light, low carbohydrate breakfast before 7:00 a.m.)**
- **No food after midnight if study time is before 1:00 p.m.**
- **Drink only plain (unflavored) water on day of study**
- **Call for instructions for diabetic patients**

INDICATION FOR PET/MRI. Include sufficient history to document why both PET and MRI are required.

Physician Signature _____ **Date** _____

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 if not available in BJH/WU electronic records) to
362-1032 after patient's examination has been scheduled.

COMPLETE PAGES 2 AND 3 ONLY IF STUDY IS DEMENTIA ASSESSMENT IN A MEDICARE PATIENT

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

Physician Request Form for Brain FDG-PET/MRI Imaging for Dementia

ADDITIONAL INFORMATION REQUIRED FOR MEDICARE PATIENTS UNDERGOING DEMENTIA EVALUATION

Patient Name _____ **Birthdate** _____

Important: Please ensure that your referral qualifies for Medicare reimbursement according to the specific criteria detailed below. See http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=104 for more information. Medicare regulations require that we collect this information before performing the study. If you have any concerns regarding the validity of a referral for Medicare reimbursement, contact **our physicians directly at (314) 362-2802.**

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 a recent diagnosis of dementia (with a documented cognitive decline for at least 6 months) that meets criteria for both Alzheimer's disease (AD) and frontotemporal dementia (FTD).

☐ The onset, clinical presentation, or course of cognitive impairment is such that FTD is suspected as an alternative neurodegenerative cause of the cognitive decline.

☐ The patient has been evaluated for specific alternative neurodegenerative diseases and the cause remains uncertain.

☐ The patient has had a comprehensive clinical evaluation (as defined by the American Academy of Neurology) encompassing a medical history from the patient and a well-acquainted informant (including assessment of activities of daily living), physical and mental status examination (including formal documentation of cognitive decline occurring over at least six months) aided by cognitive scales or neuropsychological testing, laboratory tests, and structural imaging such as magnetic resonance imaging (MRI) or computed tomography (CT).

☐ The evaluation did not clearly determine a specific neurodegenerative disease or other cause for the clinical symptoms, and information available through FDG-PET is reasonably expected to help clarify the diagnosis between FTD and AD and help guide future treatment.

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

☐ A brain single-photon emission computed tomography (SPECT) or FDG-PET has NOT previously been obtained for the same indication, or was obtained more than one year ago and was inconclusive.

All other uses of FDG-PET for patients with a presumptive diagnosis of dementia-causing neurodegenerative disease (e.g., possible or probable AD, clinically typical FTD, dementia of Lewy bodies, or Creutzfeld-Jacob disease) for which CMS has not specifically indicated coverage continue to be noncovered.

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

Physician Request Form for Brain FDG-PET/MRI Imaging for Dementia

Please provide ALL of the following required specific information:

Date of onset of symptoms: _____

Mini mental status exam (MMSE) or similar test score: _____

Specify test if not MMSE: _____

Report from any neuropsychological testing performed (please summarize):

Diagnosis of clinical syndrome (check appropriate box):

Dementia: ☐Mild ☐Moderate ☐Severe ☐Mild cognitive impairment ☐Other (specify) _____

Presumptive cause (check appropriate box): ☐Uncertain AD ☐Possible AD ☐Other _____

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

Relevant laboratory tests (B12, thyroid function tests, other) _____

Vitamin B12: _____

Thyroid Function Tests: _____

Other (specify): _____

List all prescribed medications:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

9. _____ 10. _____

By signing this request form I acknowledge full responsibility for the information that must be maintained in this patient's medical record in my office. I have verified that all conditions described above have been met. Upon request I will make this documentation available to the provider and/or to CMS, its agents or other authorized personnel for review.

Physician Signature _____ Date _____

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

Print Name _____ DOB _____