Mallinckrodt Institute of Radiology - Barnes-Jewish Hospital
Physician Request Form for Prostate Cancer (C-11 Choline or FACBC) PET/MRI

Patient Name ______________________ Date of Study ______________

DOB __________ Gender ______________ Weight ______ lbs

Patient's Address ______________________________

City, State, Zip ______________ Patient's Phone ______________

Physician ______________ Physician's Phone/Pager ______________

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

Previous PET Study Date ______________ **Outside Study?** ________ **Images in LILA?** ______

Previous MRI or CT ______________ **Outside Study?** ________ **-Images in LILA?** ______

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

STUDY REQUESTED

☐ Standard body study (skull base to proximal thighs) [CPT 78815]

Specify whether study is to be done with:

- ☐ Either agent (based on availability)
- ☐ C-11 choline (Drug code A9515)
- ☐ F-18 Fluciclovine (FACBC) (Drug Code A9588)

INSTRUCTIONS FOR MD OFFICE AND PATIENT

- Nothing by mouth, except for water, for at least 6 hours before appointment time
- The patient should be well hydrated

SPECIFIC REASON FOR C-11 Choline-PET/MRI(Check One)

❑ **Suspected Recurrence** of previously treated prostate cancer

❑ **Initial Staging** of confirmed, newly diagnosed medium- or high-risk prostate cancer

(This off-label indication is not covered by Medicare and may not be covered by other insurers.)

DEDICATED MRI STUDY REQUESTED (Must Check at Least One)

❑ Chest (71552) ❑ Abdomen (74183) ❑ Pelvis (72197)
❑ Abdomen & Pelvis (74183 & 72197) ❑ Head & Neck (70543)
❑ Other ______________

When was prostate cancer diagnosed? ________ Gleason Score ______ Original PSA ____ ng/mL

Treatment (check all that apply/indicate year): ❑ Rad. prostatectomy ______ ❑ Radiation ________ ❑ ADT ____
❑ Other (specify): ______________________________

❑ No treatment yet for prostate cancer

PSA nadir after treatment (if applicable) ____ ng/mL Current PSA ____ ng/mL Date ______________

Results of other imaging studies (summarize or attach reports):

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Additional History or Instructions: ______________________________

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