Mallinckrodt Institute of Radiology - Barnes-Jewish Hospital

Physician Request Form for Brain Amyloid-PET/MRI

Patient Name: _____ **Requested Date of Study:** _____
Birthdate: _____ **Gender:** _____ **Weight:** ____ **lbs**
Patient's 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?** _____

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 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 the radiopharmaceutical, it is essential that scheduled patients do not decide to opt out of the test when they arrive at the CCIR. **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):

☐ Mild cognitive impairment

Dementia: ☐ Mild Severity ☐ Moderate Severity

☐ Other (specify): _____

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

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

_____

_____

<u>If available, provide CD of recent brain CT and/or MRI performed at outside facilities to allow for direct comparison with the amyloid PET images.</u>

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).
<u>Please FAX this form (and recent office notes, radiology reports and pathology reports) to 314-362-1032 after patient's examination has been scheduled.</u>