Mallinckrodt Institute of Radiology - Barnes-Jewish Hospital

Physician Request Form for F-18 Fluoroestradiol (FES) PET/CT

Patient Name: _____ Gender: _____ DOB: _____ Weight _____ lbs

Patient's Address: _____ _____

City, State, Zip _____ Patient's Phone: _____

Physician: _____ Physician's Phone: _____

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

STUDY REQUESTED

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

☐ Myeloma/Melanoma study (skull vertex to knees including arms (CPT 78815)

INSTRUCTIONS FOR MD OFFICE AND PATIENT

- Endocrine therapies that block ER: tamoxifen, raloxifene and toremifene or similar agents should be stopped for 2 months and fulvestrant should be stopped for 4 months before FES-PET/CT. The oral SERD elacestrant should be stopped for 2 weeks before FES-PET/CT.

Specific Reason for Study: To document estrogen-receptor (ER) status of breast cancer that is now:

☐ **Locally Recurrent** ☐ **Metastatic**

NOTE: This test is not appropriate for liver-only or liver-dominant metastatic disease.

☐ I confirm the patient does not have liver-only/dominant disease.

NOTE: We recommend recent FDG-PET/CT for comparison in patients with bone-only/bone-dominant disease.

☐ Not applicable. Patient does not have bone-only/dominant disease.

☐ Patient has bone-only/dominant disease. FDG-PET/CT done recently; Date: _____

☐ Patient has bone-only/dominant disease. FDG-PET/CT ordered to be done first.

NOTE: This study cannot be done if patient is currently being treated with a SERM (tamoxifen, raloxifene, toremifene) or a SERD (fulvestrant or elacestrant), or has had recent use of these drugs.

☐ I confirm no tamoxifen, raloxifene or toremifene within 2 months, no fulvestrant within 4 months and no elacestrant within 2 weeks.

☐ The patient has had one of the above drugs recently, and therefore this study cannot be performed.

Patient's tumor was confirmed to be ER positive by: ☐ Primary tumor pathology ☐ Metastatic lesion pathology.

Current site(s) of proven or suspected disease: _____

Current endocrine therapy (specify): _____

Excluding neoadjuvant and adjuvant therapy, what line of endocrine therapy is this for recurrent/metastatic disease:

☐ First: ☐ Second: ☐ Third or greater

Physician Signature _____ Date: _____

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 and a representative from the PET Department will call the patient to schedule the examination.

If you have questions please call 314-362-4PET (314-362-4738) or 888-362-4PET (888-362-4738)