Mallinckrodt Institute of Radiology - Barnes-Jewish Hospital
Physician Request Form for Brain Tau PET Imaging

Patient Name ______________________ Birthdate ______________________
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? __________

Due to the high cost of the radiopharmaceutical that is ordered for this examination, it is essential that scheduled patients do not decide to opt out of the test when they arrive at the PET facility. Please explain this to your patient before referring them for the study.

For questions, please call 314-362-4PET (314-362-4738) or 888-362-4PET (888-362-4738)

Please note that this examination must be ordered by a neurologist.

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): ______________________

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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) ______________________

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If available, provide CD of recent brain imaging studies performed at outside facilities to allow for direct comparison with the Tau PET images.

Please complete and sign page 2 of this form:

Physician Request Form for Brain Tau 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 Tau 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 ______________________

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

Please FAX this form (and recent office notes, radiology reports, and other relevant reports, if not available in BJH/WU electronic medical 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).