RIO GRANDE CANCER SPECIALISTS

Providing HOPE through compassionate quality care.

Scheduling: 915.225.2015 | Fax: 915.207.2104

PET/CT Referral Form

PATIENT INFORMATION

Patient Name ____ Date of Birth ____ Height ____ Weight ____

Patient Address ____ Patient Telephone # ____ Patient Mobile # ____

Referring Provider ____ Provider Telephone # ____ Provider Fax# ____

SIGNS AND SYMPTOMS (REQUIRED)

Type of cancer ____ ○ Histologically Proven ○ Suspected

CPT Codes ____
If provided a specific CPT code, please provide.

Please check Radiopharmaceutical
○ FDG ○ PSMA

INSURANCE INFORMATION

Primary Insurance ____

Secondary Insurance ____

DESIGNATED OFFICE CONTACT FOR MEDICAL RECORDS

NAME ____ **PHONE NUMBER** ____ **EMAIL ADDRESS** ____

(Check ONE and fill out corresponding section completely)

Initial Treatment Strategy

○ **Diagnosis:** Abnormal finding of ____
Based on ____
Check one
- ○ To determine whether the patient is a candidate for an invasive diagnosis or therapeutic procedure;
- ○ To determine the optimal anatomic location for an invasive procedure; or
- ○ To determine the anatomic extent of the tumor when the treatment recommendations depend on the extent,

○ **Initial Staging:** of confirmed newly diagnosed cancer
Check one
- ○ To determine whether the patient is a candidate for an invasive diagnosis or therapeutic procedure;
- ○ To determine the optimal anatomic location for an invasive procedure; or
- ○ To determine the anatomic extent of the tumor when the treatment recommendations depend on the extent.

Other (e.g., Alzheimer's Disease). Please list reason for scan here: ____

Subsequent Treatment Strategy

○ **Restaging:** (after the completion of treatment)
Check one
- ○ Status post the completion of treatment for the purpose of detecting residual disease
  Last date of treatment: ____
  Type of treatment: ____
- ○ Detecting suspected recurrence, or metastasis of previously treated cancer:
  Site of suspected recurrence / metastasis: ____
  Based on: ____
- ○ Determine the extent of a known recurrence.
  Confirmed by: ____
- ○ PET/CT is being used to potentially replace one or more imaging studies that (1) is being utilized to determine extent of known recurrence of (2) provided insufficient information for the clinical management of the patient.

○ **Monitoring Tumor Response:** During Treatment
Check one
○ Chemotherapy ○ Radiotherapy ○ Other (specify): ____

PRESCREENING QUESTIONNAIRE

Pregnant: ○ Y ○ N
Diabetes: ○ Y ○ N

Prior Studies/Treatment

Previous:	○ CT ○ MRI ○ PET/CT	Where: ____	When: ____
Pathology:	○ Y ○ N	Where: ____	When: ____
Radiation Therapy:	○ Y ○ N	Provider: ____	When: ____
Chemotherapy:	○ Y ○ N	Provider: ____	When: ____

Authorized Treating Provider's Signature: ____ **NPI #** ____ **Date** ____

Please FAX this form (and recent office notes, radiology reports and pathology reports) to our Scheduling Department for the patient to be scheduled.