

**PET/CT ORDER
IMAGING SERVICES**

PLACE LABEL HERE

Imaging Scheduling:

Phone: 678-312-3444

Fax: 678-442-9736

Precertification: 678-312-4095

Location of Scheduled Appointment:

-
- 631 Professional Building
-
- Suite 190

GMC to Schedule Patient? Yes No

 Patient already scheduled? Yes No

Appointment Date: _____

Arrival Time: _____

Exam Time: _____

GMC to Precert Patient? Yes No

If yes, copy of insurance card & clinical documentation must be sent with order

 Medicare? Yes No

Precertification # : _____

NAME: _____

DOB: _____

Phone#1: _____

Phone#2: _____

Language: _____

Allergies: _____

Symptoms/Diagnosis/Tumor:

PATIENT MUST BRING THIS ORDER ON THE DATE OF SERVICE.
IMAGING WILL EVALUATE GFR PRIOR TO CONTRAST ADMINISTRATION UNLESS RESULTS ARE WITHIN 7 DAYS. RESULTS: _____

**A low-dose, non-contrast CT scan is performed as a part of every PET/CT scan. The CT portion of the PET scan is for reference only and no report is generated. If a CT of diagnostic quality is desired, a separate exam must be ordered.*

Orders for PET scan	
<input type="checkbox"/> Standard Scan (skull base through mid thigh)	ICD-9 Code: <input type="checkbox"/> Initial Staging <input type="checkbox"/> Restaging
<input type="checkbox"/> Whole Body Scan (head through toes)–Melanoma patients ONLY	<input type="checkbox"/> Assess Response During TX
<input type="checkbox"/> Brain Imaging (tumor, dementia, alzheimer's etc.)	<input type="checkbox"/> Assess Response Following TX
<i>You must select CT orders to correlate with PET</i>	
Diagnostic CT of: <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Brain <input type="checkbox"/> Neck <input type="checkbox"/> Other: _____	<input type="checkbox"/> Contrast per Radiologist Discretion
<input type="checkbox"/> CT for PET Attenuation only <i>(non-diagnostic and NO report given)</i>	<input type="checkbox"/> With Contrast <input type="checkbox"/> Without Contrast
Prior PET Scans: Date: _____ Location: _____	<input type="checkbox"/> With and Without Contrast
Prior CT Scans: Date: _____ Location: _____	

PHYSICIAN NAME (PRINT): _____ **DATE:** _____ **TIME:** _____ **FAX RESULTS:** _____

PHYSICIAN SIGNATURE: _____ **PHYSICIAN'S ID#:** _____ **NPI** _____

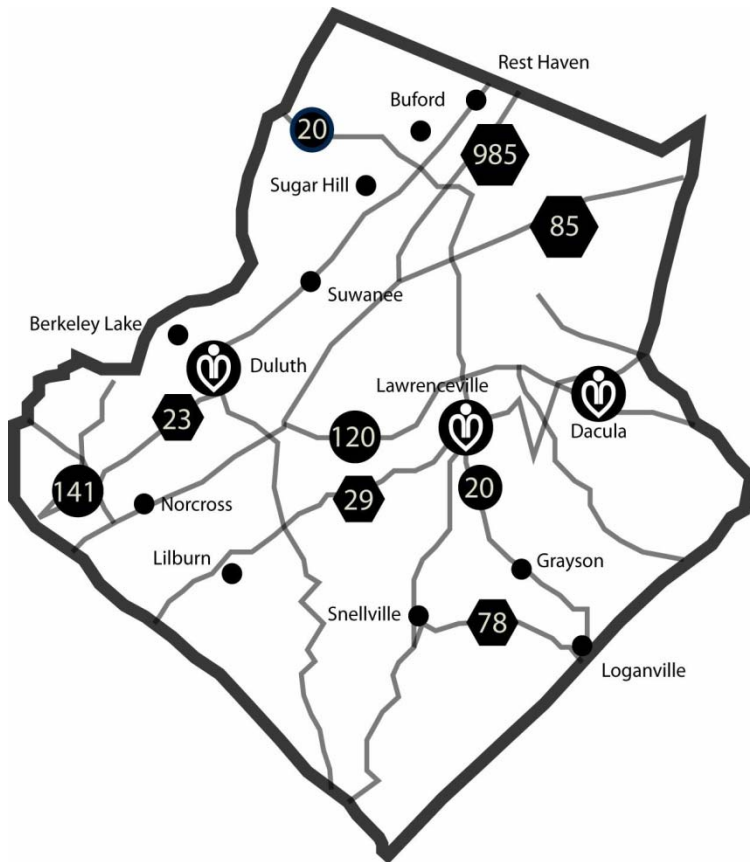
2-26113

FORM 2-26113 REV. 10/2010

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For directions, go to WWW.GMCIMAGING.ORG and click onto the facility where you are scheduled.



Gwinnett Medical Center Lawrenceville
1000 Medical Center Blvd
Lawrenceville, GA 30046
678-312-4321

Gwinnett Medical Center Duluth
3620 Howell Ferry Rd
Duluth, GA 30096
678-312-6805

575 Outpatient Imaging Center
575 Professional Drive
Lawrenceville, GA 30046
678-312-5300

631 Professional Drive
Suite 190
Lawrenceville, GA 30046
PET/CT ONLY

Tests should only be ordered that are medically necessary for the diagnosis, symptoms, and /or treatment. The patient may be billed for tests that are NOT deemed necessary by payors. Please submit all (appropriate) clinical indications for all test (s) ordered. The procedure will **NOT** be performed in the absence of the completed form including the appropriate diagnosis and/or ICD-9 codes supporting the ordered procedure. Ordering physicians are responsible for the accuracy of the information provided.