

Pre-PET Form
National Oncologic PET Registry

Please fax this form along with a script, copy of insurance cards, recent CT/MRI reports, any pathology reports and the NOPR Pre-PET Form to fax # (609) 677-1499.
If you have any questions, please call (609) 652-3375.

- You have requested a PET scan for an indication for which the Centers for Medicare and Medicaid Services (CMS) requires pre- and post-PET information prior to approving the study for reimbursement. In order for the imaging center to be reimbursed this form must be completed and returned to the PET facility before the PET scan is performed. You also will be sent by e-mail and required to complete a follow-up form about one week after the PET scan is done. Thank you for your assistance completing the brief pre- and post-PET forms.

PET Facility ID #: _____ Registry Case #: _____

PATIENT INFORMATION

Date: ____/____/____

First Name: _____ Last Name: _____

Date of Birth ____/____/____

SSN#: _____

REFERRING PHYSICIAN

First Name: _____ Last Name: _____ UPIN#: _____

Office Telephone: (____) _____ Office Fax: (____) _____

Your preferred E-mail Address: _____

Comment to Clinician: The follow-up questionnaire will be sent to you by e-mail.

1. SPECIFIC REASON FOR PET STUDY

a. Check the single best match for the reason for the PET (*you must check only one of the following and then answer the section(s) indicated for question 2*)

- Diagnosis:** To determine if a suspicious lesion is cancer (answer 2a and 2b)
- Diagnosis/Unknown Primary Tumor:** To detect a primary tumor site in a patient with a confirmed metastatic lesion (answer 2c)
- Diagnosis/Paraneoplastic:** To detect a primary tumor site in a patient with a presumed paraneoplastic syndrome (answer 2a and 2b)
- Initial Staging** of histologically confirmed, newly diagnosed cancer (answer 2a and 2b)
- Monitoring Treatment Response** during chemotherapy (answer 2a and 2b)
- Monitoring Treatment Response** during radiation therapy (answer 2a and 2b)
- Monitoring Treatment Response** during combined modality therapy (e.g., chemo ± radiation ± surgery ± biologic therapy) (answer 2a and 2b)
- Restaging** after completion of therapy (answer 2a and 2b)
- Suspected Recurrence** of a previously treated cancer (answer 2a and 2b)

2. CANCER TYPE AND WORKING STAGE

- For a patient with a known primary or clinically suspected cancer, please mark the corresponding box of the cancer type in section 2a and answer question 2b. For a patient with metastatic disease of unknown primary origin, mark the corresponding box of the site of metastatic disease in section 2c. If your patient's cancer is not listed, check the Other box and enter as text the cancer type.
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a. Cancer Type (ICD-9 Code) - check the one cancer that most closely relates to the specific reason for the PET study indicated in response to Question 1. (Check only one)

- | | |
|---|---|
| <input type="checkbox"/> Lip, Oral Cavity, and Pharynx (140-149) | <input type="checkbox"/> Melanoma of skin (172) |
| <input type="checkbox"/> Esophagus (150) | <input type="checkbox"/> Female breast (174) |
| <input type="checkbox"/> Stomach (151) | <input type="checkbox"/> Male breast (175) |
| <input type="checkbox"/> Small Intestine (152) | <input type="checkbox"/> Kaposi's sarcoma (176) |
| <input type="checkbox"/> Colon (153) and Rectum (154) | <input type="checkbox"/> Uterus, unspecified (173) |
| <input type="checkbox"/> Anus (154) | <input type="checkbox"/> Cervix (180) |
| <input type="checkbox"/> Liver and intrahepatic bile ducts (155) | <input type="checkbox"/> Uterus, body (182) |
| <input type="checkbox"/> Gallbladder & extrahepatic bile ducts (156) | <input type="checkbox"/> Ovary and uterine adnexa (183) |
| <input type="checkbox"/> Pancreas (157) | <input type="checkbox"/> Prostate (185) |
| <input type="checkbox"/> Retroperitoneum and peritoneum (158) | <input type="checkbox"/> Testis (186) |
| <input type="checkbox"/> Nasal cavity, ear, and sinuses (160) | <input type="checkbox"/> Penis and other male genitalia (187) |
| <input type="checkbox"/> Larynx (161) | <input type="checkbox"/> Bladder (188) |
| <input type="checkbox"/> Lung, non-small cell (162) | <input type="checkbox"/> Kidney and other urinary tract (189) |
| <input type="checkbox"/> Lung, small cell (162) | <input type="checkbox"/> Eye (190) |
| <input type="checkbox"/> Pleura (163) | <input type="checkbox"/> Primary Brain (191) |
| <input type="checkbox"/> Thymus, heart, mediastinum (164) | <input type="checkbox"/> Thyroid (193) |
| <input type="checkbox"/> Bone/cartilage (170) | <input type="checkbox"/> Lymphoma (200-202) |
| <input type="checkbox"/> Connective/other soft tissue (171) | <input type="checkbox"/> Myeloma (203) |
| <input type="checkbox"/> Leukemia (204-208) | |
| <input type="checkbox"/> Other or not listed. Please describe cancer type _____ | |

b. Has this cancer diagnosis been pathologically proven? Yes No

c. Unknown primary: site of pathologically proven metastatic disease (196-199)

- | | |
|---|---|
| <input type="checkbox"/> Lymph node(s) | <input type="checkbox"/> Brain |
| <input type="checkbox"/> Lung | <input type="checkbox"/> Bone/bone marrow |
| <input type="checkbox"/> Liver | |
| <input type="checkbox"/> Other. Specify _____ | |



Pre-PET Form

Patient's Name: _____ **DOB:** _____

Home Phone Number: () _____

Requesting Physician: _____

Physician Phone: () _____

Reason for PET Scan (Primary Diagnosis): _____

When was this Diagnosed? _____

Has the patient had a previous PET scan with AMI? _____

Patient's weight: _____

Date completed Chemotherapy: _____ **Radiation:** _____

Any recent surgery in the past few weeks? _____

Is there any history of Melanoma? _____

Is the patient Diabetic? _____

Primary Insurance: _____ **ID#:** _____

Secondary Insurance: _____ **ID#:** _____

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