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**REQUEST FOR SERVICE FORM**

**PATIENT INFORMATION:** Today's Date \_\_\_\_\_ Date Scan Is Needed By \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Weight \_\_\_\_\_ ICD-9 Code \_\_\_\_\_

Primary Diagnosis \_\_\_\_\_

Special Notes \_\_\_\_\_

**PLEASE FAX A COPY OF THE FRONT AND BACK OF THE PATIENT'S CURRENT INSURANCE CARD AND ALL PRIOR IMAGING REPORTS**

**HYBRID PET/CT**

**Standard Whole Body Oncology Protocol (Skull-base to mid-thighs/78815)** Histology proven?  Yes  No

**Non-Standard Protocol** (Please specify): \_\_\_\_\_  
 (i.e. 78816- Melanoma or inclusion of vertex and/or extremities, 78608- Brain, 78814- Limited area)

**Whole Body PET/CT + Diagnostic CT:** (Please attach a copy of the most recent Creatinine lab results)

Brain  Neck  Chest  Abdomen  Pelvis  Other:

**Please do not administer IV contrast**

Tumor Type	Initial Treatment	Subsequent Treatment	*
<input type="checkbox"/> Brain	<input type="checkbox"/> Covered	<input type="checkbox"/> NOPR	<p><b>NOPR (National Oncology PET Registry) Clinical Trial For Medicare Patients</b></p> <p>1* Breast: Not covered for diagnosis and/or initial staging of axillary lymph nodes. Covered for initial staging of metastatic disease.</p> <p>2* Cervix: Covered for the detection of pre-treatment metastases (i.e. staging) in newly diagnosed cervical cancer subsequent to conventional imaging that is negative for extra-pelvic metastasis. All other uses are NOPR.</p> <p>3* Melanoma: Not covered for initial staging of regional lymph nodes. All other uses for initial staging are covered.</p> <p>4* Thyroid: Covered for subsequent treatment strategy of recurrent or residual thyroid cancer of follicular cell origin previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin &gt;10ng/ml and have a negative I-131 whole body scan. All other uses for subsequent treatment strategy are NOPR.</p>
<input type="checkbox"/> Breast (Female and Male)	<input type="checkbox"/> 1*	<input type="checkbox"/> Covered	
<input type="checkbox"/> Cervix	<input type="checkbox"/> 2* or NOPR	<input type="checkbox"/> Covered	
<input type="checkbox"/> Colorectal	<input type="checkbox"/> Covered	<input type="checkbox"/> Covered	
<input type="checkbox"/> Esophagus	<input type="checkbox"/> Covered	<input type="checkbox"/> Covered	
<input type="checkbox"/> Head and Neck (Not thyroid or CNS)	<input type="checkbox"/> Covered	<input type="checkbox"/> Covered	
<input type="checkbox"/> Lymphoma	<input type="checkbox"/> Covered	<input type="checkbox"/> Covered	
<input type="checkbox"/> Non Small Cell Lung	<input type="checkbox"/> Covered	<input type="checkbox"/> Covered	
<input type="checkbox"/> Melanoma	<input type="checkbox"/> 3*	<input type="checkbox"/> Covered	
<input type="checkbox"/> Myeloma	<input type="checkbox"/> Covered	<input type="checkbox"/> Covered	
<input type="checkbox"/> Ovary	<input type="checkbox"/> Covered	<input type="checkbox"/> Covered	
<input type="checkbox"/> Pancreas	<input type="checkbox"/> Covered	<input type="checkbox"/> NOPR	
<input type="checkbox"/> Prostate	<input type="checkbox"/> N/C	<input type="checkbox"/> NOPR	
<input type="checkbox"/> Small Cell Lung	<input type="checkbox"/> Covered	<input type="checkbox"/> NOPR	
<input type="checkbox"/> Solitary Pulmonary Nodule (8 mm - 4 cm)	<input type="checkbox"/> Covered	<input type="checkbox"/> Covered	
<input type="checkbox"/> Soft Tissue Sarcoma	<input type="checkbox"/> Covered	<input type="checkbox"/> NOPR	
<input type="checkbox"/> Testes	<input type="checkbox"/> Covered	<input type="checkbox"/> NOPR	
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Covered	<input type="checkbox"/> 4* or NOPR	
<input type="checkbox"/> All Other Solid Tumors	<input type="checkbox"/> Covered	<input type="checkbox"/> NOPR	
<input type="checkbox"/> All Other Cancers Not Listed (Excluding Solid Tumors)	<input type="checkbox"/> NOPR	<input type="checkbox"/> NOPR	

**DIAGNOSTIC CT**  **With IV Contrast**  **Without IV Contrast** (Please attach a copy of the most recent Creatinine lab results)

Brain  Neck  Chest  Abdomen  Pelvis  Other:

**REQUESTING PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ Name \_\_\_\_\_

UPIN \_\_\_\_\_ Submitted By \_\_\_\_\_ Office # \_\_\_\_\_ Fax # \_\_\_\_\_

Authorization Number \_\_\_\_\_ **CC :**  Reports \_\_\_\_\_