

Imaging Order



PET/CT Referral Form

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Diplomate, American Board of Radiology

Date _____

PET/CT Scheduler: (850) 481-1687

Fax Orders: (850) 640-0761

PSMA Scheduler: (850) 481-1687

PATIENT LAST NAME (REQUIRED), FIRST NAME (REQUIRED)		HEIGHT (REQUIRED)	WEIGHT (REQUIRED) lbs
DATE OF BIRTH (REQUIRED)	PATIENT DAYTIME PHONE		OTHER PHONE
ORDERING CLINICIAN (REQUIRED)	CLINICIAN SIGNATURE (REQUIRED - NO STAMPS)		
ORDERING CLINICIAN'S FAX NUMBER (WHERE REPORT SHOULD BE SENT)	ORDERING CLINICIAN'S NPI		
OFFICE PHONE NUMBER	SEND ADDITIONAL COPIES OF REPORT TO (Name and Fax#)		
INSURANCE	PA# and date range (Must be obtained by ordering physician's office)		

PLEASE SELECT REQUESTED PET/CT

_____ Skull Base to Thigh Oncology General (routine) 78815, A9552

_____ Whole Body Oncology General (e.g. Melanoma) 78816, A9552

_____ PSMA 78815, A9608

DIAGNOSES (see attached list of insurance approved diagnosis codes)

1) _____ 2) _____

PLEASE FAX ALL APPLICABLE DOCUMENTS with this order sheet

- 1) Patient demographic information
- 2) Prior authorization (obtained from ordering physician's office for HMO plans and UHC)
- 3) Prior imaging related to current diagnosis
- 4) Prior pathology related to current diagnosis
- 5) Labs – PSA Level for PSMA



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