UNIVERSITY OF KANSAS PET MEDICAL NECESSITY FORM PHYSICIAN APPROVAL _____
FAX to (913)588-0235

PATIENT NAME:	PATIENTS INSURANCE:	PRE-CERTIFICATION NUMBER:
MEDICAL RECORD #	WORK PHONE #:	___FEMALE (Age 12-50) PREGNANT ___YES
BIRTHDATE: AGE:	HOME PHONE #:	___MALE ___NO
ADDRESS:		

_____INPATIENT _____UNIT _____RM# _____EXT.
_____DIABETIC _____BLOOD SUGAR LEVEL _____WEIGHT _____HEIGHT

DURING PET SCAN PATIENT WILL NEED:
____ FOLEY CATHETER ____ IV SEDATION ____ PO VALLIUM

CONTACT PERSON/RESIDENT:	PHONE #:	DATE OF SCAN:	TIME:
REFERRING/ATTENDING DR:	FAX REPORT TO:	MAIL REPORT TO:	E-MAIL REPORT TO:

PROCEDURE TYPE:
____ PET BRAIN METABOLISM ____ PET HEART METABOLISM ____ PET TUMOR METABOLISM
____ PET BRAIN PERFUSION ____ PET HEART PERFUSION

DIAGNOSIS CODE:
_____
_____
_____

RATIONALE FOR PET SCAN:
_____
_____
_____

____ DIAGNOSIS
____ STAGING
____ RESTAGING
____ SOLITARY PULM. NOD.

FILMS	DATE	BODY SITE	FILM LOCATION/PHONE NUMBER

PRIMARY DIAGNOSIS:	DATE OF DIAGNOSIS:	TUMOR MARKER MONITORING: TUMOR MARKER	DATE:
KNOWN METS:	DATE OF DIAGNOSIS:		

	PROCEDURE/TYPE:	DATE:	LOCATION:	AMOUNTS:
SURGERY / BIOPSIES	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
RADIATION THERAPY	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
CHEMO THERAPY	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
IMMUNO THERAPY	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

DATE SCHEDULED_____ SCHEDULED BY:_____