**UNIVERSITY OF KANSAS PET MEDICAL NECESSITY FORM**  
**PHYSICIAN APPROVAL** ______________________  
**FAX TO 588-1823**

**PATIENT NAME:**  
**PATIENTS INSURANCE:**  
**PRE-CERTIFICATION NUMBER:**

**MEDICAL RECORD #:**

**ADDRESS:**  
___ FEMALE

**WORK PHONE #:**  
(age 12-50)  
Pregnant __ No __ Yes

**HOME PHONE #:**  
___ MALE

**BIRTHDATE:**  
**AGE:**  
___ INPATIENT  
HOSPITAL UNIT:  
___ EXTENSION:

___ OUTPATIENT  
___ DIABETIC

**REFFERAL DATE CALL TAKEN INTERVIEWED BY:**

**CONTACT PERSON/RESIDENT:**  
**PHONE #:**  
**DATE OF SCAN:**  
**TIME:**

**REFERRING/ATTENDING DR:**  
**FAX REPORT TO:**  
**MAIL REPORT TO:**  
**E-MAIL REPORT TO:**

**DIAGNOSIS CODE:**  
**RATIONALE FOR PET SCAN:**

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**PROCEDURE TYPE:**  
___ PET BRAIN METABOLISM  
___ PET HEART METABOLISM  
___ PET TUMOR METABOLISM  
___ PET BRAIN PERFUSION  
___ PET HEART PERFUSION

**DURING PET SCAN PATIENT WILL NEED:**  
___ FOLEY CATHETER  
___ IV SEDATION  
___ PO VALLUM  
___ GLUCOSE LEVEL

**FILMS**  
**DATE**  
**BODY SITE**  
**FILM LOCATION/PHONE NUMBER**

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**PRIMARY DIAGNOSIS:**  
**DATE OF DIAGNOSIS:**  
**TUMOR MARKER MONITORING:**  
**TUMOR MARKER**  
**DATE:**

**KNOWN METS:**  
**DATE OF DIAGNOSIS:**

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**PROCEDURE/TYPE:**  
**DATE:**  
**LOCATION:**  
**AMOUNTS:**

**SURGERY/BIOPSIES**

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**RADIATION THERAPY**

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**CHEMO THERAPY**

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**IMMUNO THERAPY**

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