4 Neshaminy Interplex
Suite #209
Trevose, PA 19053

Diagnostic Imaging, Inc.

Telephone: (215) 638-9040
Facsimile: (215) 638-9041

PET-CT IMAGING REQUEST
At Aria Health

Fax to Pat (215) 638-9041

Appointment Time:_____
(to be assigned by Central Scheduling)

Patient Information

Name:		Date Ordered:
Address:		C,S,Z
Date of Birth:	Height:	Weight:
Home Phone:	Cell Phone:	Work Phone:

Physician Information

Referring Physician	Dr. Phone #	Dr. Fax #
☐ Fax Results: _____ ☐ Phone Results: _____		Send Copies To:

Insurance Information

Primary Insurance:		Benefits Phone
Plan ID Nos.	Group:	Pre-Certification No.
Secondary Insurance		ID/Group No.

PET-CT IMAGING CPT CODES

Check One and Indicate Diagnosis Code

PET-CT Study	Diagnosis Code
☐ 78814 Limited Study (Chest, Head/Neck)	
☐ 78815 Skull Base to Mid-thigh (This is the standard PET-CTScan that willl be provided in most cases)	
☐ 78816 Whole Body (Melanoma)	
☐ 78608 Brain Imaging (Alzheimer's) **PET ONLY**	

PROVIDER NOTICE TO PATIENT REGARDING NO-SHOW POLICY

DII will order a Radiopharmaceutical, which is estimated to cost $300. The life expectancy of this Radiopharmaceutical is very short and is calibrated to your specific needs: therefore, it cannot be reassigned to another patient. If for any reason you electively cancel your procedure with less than 48 hours notice, you will be liable for the cost of the Radiopharmaceutical. However, should your physician determine that you are unable to undergo your PET-CT scan, and as a result cancels your scan for medical reasons, you would not be held liable. I have read the above and am in complete agreement with Diagnostic Imaging's no show policy.

PATIENT SIGNATURE: _____ **DATE:** _____

Patient Information	**Prior Study Information**
Diabetes: ____ Yes ____ No _____ Insulin _____ Oral Meds	Was a CT, MRI or PET Scan performed within the last 12 months? _____ Yes _____ No If yes, where were exams performed?
Pregnant/Breastfeeding: _____ Yes _____ No	
Cancer Treatment: _____ Radiation Therapy _____ Chemotherapy Date of Last Treatment: _____	
Is Patient Claustrophobic? _____ Yes _____No	Please fax reports with this request form.

SIGNATURE OF REQUESTING PHYSICIAN: _____

Please fax completed request form to (215) 638-9041 – Attention: Patricia Slobodian