## STOCKTON HEMATOLOGY ONCOLOGY MEDICAL GROUP, INC.

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# SHOMG PET/CT ORDER FORM

**Phone (209)292-8542 Fax (209)932-9298**

**PATIENT NAME:** _____ **DOB:** _____
**HT:** _____**in. WT:** _____**lbs.** **Diagnosis Code:**_____

**DIAGNOSIS:**

| | | | |
|---|---|---|---|
| □ | Solitary Lung Nodule | □ | Brain Mets 2nd to primary diagnosis |
| □ | Brain Tumor (dedicated brain must have MRI prior) | □ | Thyroid |
| □ | Cervical Cancer | □ | Colorectal Cancer |
| □ | Breast Cancer | □ | Lymphoma |
| □ | Esophageal Cancer | □ | Lymphoma-cutaneous and/or bone (whole body scan) |
| □ | Lung Cancer (Non-Small Cell) | □ | Head and Neck Cancers |
| □ | Lung Cancer (small cell) | □ | Pancreatic Cancer |
| □ | Ovarian Cancer | □ | Melanoma (whole body scan) |
| □ | Testicular Cancer | □ | Soft Tissue Sarcomas |
| □ | Other Indications_____ | | |

**Please check one of the following: Include on request for authorization:**

□ 78815 Skull base to mid-thigh □ 78816 Whole Body Scan □ 78815 Vertex to mid thigh

**Please check one of the following: Include on request for authorization:**

□ A9552 (F-18 FDG Dose) quantity 1 units □A9595 Pylarify(PSMA) quantity 9 units

**Please check one of the following:**

□ Initial treatment Strategy
(Formerly "diagnosis" & "Staging")

□ Subsequent Treatment Strategy
(Formerly "restaging" & "monitoring response to TRT)

Referring physician Signature_____ Date_____

****PSA REQUIRED WITHIN 90 DAYS FOR PYLARIFY ORDERS****