PET/CT Scheduling Request
FAX information to: 1-866-225-6826
any questions, call 1-866-235-7226

Southwestern Vermont MEDICAL CENTER

Today's Date:_____	Procedure Date & Time: _____ (Scheduling Center use only)

Patient's
Last Name:_____ First:_____ M.I._____ DOB: ____/____/____

Home Phone: (___) ____-_____ Work Phone: (___) ____-_____ Cell Phone: (___) ____-_____ Sex: M / F

Primary Insurance: _____ ID #: _____ Auth / Referral # _____

Ordering Physician: _____ (please print) Office Phone: (____) ____ - _____ Office Fax: (____) ____ - _____

① Select (☑) the requested exam:

☐ PET/CT Scan Routine CPT-78815	☐ PET/CT Scan for Alzheimer's or dementia evaluation CPT-78608
☐ PET/CT Scan for Melanoma CPT-78816	

② Select (☑) the Treatment Strategy Phase:

☐ **Initial** Treatment Strategy (Diagnosis or Initial Staging) (**PI** modifier)	☐ **Subsequent** Treatment Strategy (Includes Treatment Monitoring, Restaging, or Detection of Suspected Recurrence) (**PS** modifier)	

Refer to the Tables on reverse for specific indications by treatment phase.

③ Provide an Indication and Diagnosis Code for the exam:

Indication for exam: _____

_____ Diagnosis Code: _____

Some indications may require the patient to sign an ABN.

④ Ordering Physician's Signature:_____

Please fax the following along with this Scheduling Request to 1-866-225-6826:

1) A copy of the patient's financial sheet or insurance card, and any referral or authorization forms.
2) A copy of the most recent pathology report, imaging report, and physician's progress note.