



PET/CT SCHEDULING CAMP LOWELL SPECIAL PROCEDURES

Radiology Ltd.
Diagnostic Imaging Services
Specialty Scheduling Tel: (520) 545-1906 option 3
Toll Free Tel: 1-866-565-2220 Toll Free Fax: 1-866-707-0750

Appt. Time: _____
Date: _____
Check-in Time: _____

**To schedule an appointment, please call (520) 545-1906 option 3 or fax to (520) 545-1898.
Please include all pathology, operative reports, progress notes, and prior imaging reports to ensure timely processing.**

PHYSICIAN'S NAME: _____ PHONE #: (____) _____ FAX #: (____) _____
If physician practices at multiple locations, please include address for these results to be sent: _____
PATIENT: (First Name) _____ (Last Name) _____ (Middle Initial) _____
DOB: _____ HOME PHONE: (____) _____ WORK PHONE: (____) _____ BEST TIME TO CONTACT: _____ AM PM
PATIENT INSURANCE: _____ POLICY/GROUP#: _____ INS. PHONE: (____) _____
PRIOR AUTHORIZATION # (if needed): _____ Would you like authorization assistance? YES NO
Please note: We are unable to provide authorization assistance for STAT cases and CareMore, Humana and United Healthcare insurance plans.
When scheduling, please include all clinical information and a copy of the insurance card with the order.

Specialty PET/CT Exams

(Please note: Speciality exams have to be reviewed and have limited scheduling times)

Exam Requested:

- | | | | |
|--|--|---|-------------------------------------|
| <input type="checkbox"/> PET/CT Skull Base to Mid-Thigh
(78815) <i>(all other diagnosis)</i> | <input type="checkbox"/> PET/CT Bone Scan
w/Sodium Fluoride (78816)
<i>(Sodium fluoride PET bone scans
are not covered by Medicare.)</i> | <input type="checkbox"/> PET/CT Axumin (78815) | <input type="checkbox"/> Staging |
| <input type="checkbox"/> PET/CT Myocardium (78459) | <input type="checkbox"/> PET/CT Brain (78608) | <input type="checkbox"/> PET/CT Gallium
Dotatate (78815) | <input type="checkbox"/> Re-staging |
| <input type="checkbox"/> PET/CT Whole Body (78816)
<i>(Diagnosis: Melanoma, Myeloma,
Sarcoma, and Merkel Cell Carcinoma
Cutaneous Lymphoma)</i> | <input type="checkbox"/> Other _____ | | <input type="checkbox"/> History of |

Primary Diagnosis: _____

Signs & Symptoms: _____

Special Instructions: _____

Previous Studies / Reports:

Biopsy: _____ Date: _____

CT: _____ Date: _____

MRI: _____ Date: _____

PET: _____ Date: _____

Path Avail Yes No

Referring Physician's Signature: _____ **Date:** _____

The information contained in this facsimile message is CONFIDENTIAL and/or LEGALLY PRIVILEGED information intended only for the use of the facility named above. If you have received this in error, please call (520) 545-1969.

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If you are unable to keep your appointment, please call Specialty Scheduling at (520) 545-1906 option 3 to reschedule your appointment. Cancellations made less than 24-hours prior to appointment time may be subject to a no-show fee.

