PET/CT Imaging Request

Referring Physician Information					
Name:___		Phone: ___		Fax: ___	
Patient Name		Birth Date	Sex ☐ M ☐ F	Height	Weight
Primary Phone	Work Phone		Cell Phone		
Insured Name	Plan Name		Plan Phone #		
ID#	Group#		Pre-Certification Phone #		
DIAGNOSIS/ICD Code					

☐ I, referring provider, attest that I have discussed this referral with the patient, and the patient has provided consent to the sharing of their demographic and contact information with Memorial Hermann or its affiliated providers for the purposes related to this referral, including: (1) telephone calls and text messages regarding health care, including but not limited to scheduling, reminders, and medication refills; (2) email or mail communications regarding health care, including but not limited to scheduling, reminders, and medication referrals; and (3) other information regarding my health care, billing and health related services and benefits. I have instructed the patient if they wish to revoke this consent, they may contact Memorial Hermann at 713-222-CARE (2273) or opt out directly after receipt of communication.

Provider Signature	**Print Name**	**NPI/MHHS ID.**	**Date**	**Time** ☐ **AM** ☐ **PM**	**Contact No.**

X	PET/CT
	Brain Refactory Seizures:
	Breast Cancer: ☐ Monitor Response to Therapy ☐ Initial Staging ☐ Restaging
	Cervical Cancer: ☐ Initial Staging
	Colorectal Cancer: ☐ Diagnosis ☐ Initial Staging ☐ Restaging
	Dementia
	Esophageal Cancer: ☐ Diagnosis ☐ Initial Staging ☐ Restaging
	Head & Neck Cancer: ☐ Diagnosis ☐ Initial Staging ☐ Restaging
	Lung Cancer, Non-small cell (NSCLC): ☐ Diagnosis ☐ Initial Staging ☐ Restaging

X	PET/CT
	Lymphoma: ☐ Diagnosis ☐ Initial Staging ☐ Restaging
	Melanoma (Whole body, head to toe protocol): ☐ Diagnosis ☐ Initial Staging ☐ Restaging *Head to Toe "whole body" 78816 is most often reserved for melanoma
	Myocardial: ☐ With an inconclusive SPECT Viability: ☐ Prior to revascularization
	Prostate-specific membrane antigen (PSMA) Prostate Cancer: ☐ Diagnosis ☐ Initial Staging ☐ Restaging
	Solitary Pulmonary Nodule
	Thyroid Cancer: ☐ Residual Cancer of Follicular Origin ☐ Restaging
	☐ Standard Body (eyes to thighs protocol) (78815)
	☐ Other*___

Diagnostic questions to be answered:

Surgeries: ___ **Date:** ___ **Date:** ___ **Date:** ___

Pregnant or Breast feeding: ☐ **Yes** ☐ **No** **Diabetes:** ☐ **Yes** ☐ **No** ☐ **Insulin** ☐ **Oral Meds**

Cancer Treatment: ☐ **Radiation Therapy** ☐ **Chemotherapy** **Date of last treatment** ___ ☐ **Neupogen/Neulasta**

Was a CT, MRI or PET scan performed in the last 12 months? ☐ **Yes** ☐ **No** **Where?** ___

Please fax report(s) with request.

PET/CT is available at the following Memorial Hermann locations. Indicate the preferred location by checking the designated box.

☐ **Memorial Hermann Hospital,** 6411 Fannin
Scheduling Phone: 713.704.6500, Fax: 713.704.5113

☐ **Southeast Hospital,** 11800 Astoria Blvd.
Scheduling Phone: 281.929.6485, Fax: 281.929.4710

☐ **Memorial City Hospital,** 925 Gessner, Suite 200
Scheduling Phone: 713.242.3700, Fax: 713.242.4993

☐ **Southwest Hospital,** 7789 SW Freeway
Scheduling Phone: 713.456.5150, Fax: 713.456.5179

☐ **Texas Medical Center,** 6400 Fannin St., Suite 1600
Scheduling Phone: 713.704.1203, Fax: 713.704.6551

☐ **Memorial Hermann Imaging Center - Northeast**
18955 N Memorial Dr., Suite 100
Scheduling Phone: 281.540.7995, Fax: 713.512.6041

☐ **The Woodlands,** 9200 Pinecroft, Suite 150
Scheduling Phone: 281.364.2514, Fax: 281.364.2381

PET/CT Imaging Request

PET/CT Imaging Patient Prep

Follow these instructions to get the best results from your test:

Non-Diabetic:

1. No food for 6 hours prior to appointment. You may drink **ONLY** water up to the time of your test. **No other type of liquid is allowed.**
2. Take medications as scheduled prior to your appointment as long as they can be tolerated on an empty stomach.
3. **NO** strenuous exercising 24 hours prior to your appointment.
4. Follow a high protein, low carbohydrate diet for 24 hours prior to your test. (optional)

Diabetic:

1. No food for 6 hours prior to appointment. You may drink **ONLY** water up to the time of your test. **No other type of liquid is allowed.**
2. Diabetics who take **ORAL** medication should wait until the exam is completed to take them.
3. Subcutaneous insulin-dependent diabetics should have their last injection 4 hours prior to the appointment.
4. Take other regularly scheduled medication prior to appointment as long as they can be tolerated on an empty stomach.
5. NO strenuous exercising 24 hours prior to your appointment.
6. Follow a high protein, low carbohydrate diet for 24 hours prior to your test. (optional)

In-Patients:

1. Follow either of the above protocols, and;
2. If receiving IV fluids containing glucose or parenteral alimentation, these should be discontinued 8 hours prior to the study.

All patients:

1. Wear warm, loose fitting clothing. The scanners tend to get cool. You will not be required to remove your clothing prior to the scan.
2. Allow 2-3 hours for the exam.
3. If you need pain or anxiety medication, take this one hour before the scan.
4. Avoid wearing any metal which cannot be removed during the scan.