CARTI PET / CT

☐ Little Rock	☐ North Little Rock	☐ Pine Bluff	☐ Russellville	☐ El Dorado
CARTI Cancer Center 8901 CARTI Way	CARTI Imaging Center 3400 Springhill Drive	CARTI Cancer Center 5001 Bobo Road	CARTI Cancer Center 209 South Portland Ave.	CARTI Cancer Center 1601 North West Ave.

Legal Name: Central Arkansas Radiation Therapy Institute
Mailing/Pay: PO Box 55050 • Little Rock, AR 72215
Tax ID: 71-0437657 • NPI: 1508147810

Scheduling: 501.296.3253
Fax: 501.537.8786

PATIENT REFERRAL — PAGE 1

PATIENT INFORMATION — Please Print

NAME _____

ADDRESS _____

_____

DOB___ ____ _____ EMAIL_____

PHONE_____ SSN_____

CLINIC INFORMATION

REFERRING PROVIDER (Name and NPI#)

_____

_____

FACILITY (Name and address)

_____

_____

_____

PHONE _____

FAX_____

CONTACT NAME _____

PRE-CERTIFICATION

- Our Pre-certification team will obtain all prior authorizations.
- Our imaging schedulers will contact the patient to schedule their appointment and will follow up and mail instructions/map.
- Our imaging schedulers will contact the referring physician's office with the date and time of the patient's appointment.
- Our transcription team will fax the imaging report back to the referring physician's office.

PLEASE FAX THE FOLLOWING DOCUMENTS:

- ☐ Signed order
- ☐ Signed office note with type of imaging scan in the plan
- ☐ All pathology
- ☐ All radiology
- ☐ Demographic information (face-sheet)

APPOINTMENT DETAILS

DATE _____

TIME _____

PHYSICIAN'S ORDER

TYPE OF EXAM **PET/CT (please check box on next page to specify)** _____

QUALIFYING ICD-10 AND DIAGNOSIS _____

ORDERING PHYSICIAN (PRINT) _____

ORDERING PHYSICIAN SIGNATURE _____

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PATIENT REFERRAL — PAGE 2

Patient Name_____

MRN or SSN_____ Age _____ Weight _____ Height _____

Primary Tumor Location_____Date of Diagnosis_____

☐ 78815 PET/CT **F-18 FDG** (Skull base to Mid-thigh – A9552)

☐ 78816 PET/CT **F-18 FDG** (Head to Toe – A9552)

☐ 78815 PET/CT Dotatate: ☐ **Ga-68 Dotatate** (Skull base to Mid-thigh – A9587)

☐ **Cu-64 Dotatate** (Skull base to Mid-thigh – A9592)

☐ 78815 PET/CT PSMA:

- ☐ **F-18 Pylarify** (Top skull to Mid-thigh - A9595)
- ☐ **Ga-68 Illuccix** (Top skull to Mid-thigh - A9596)
- ☐ **F-18 Posluma** (Top skull to Mid-thigh - A9608)
- ☐ **F-18 Axumin** (Skull base to Mid-thigh – A9588)

☐ 78816 PET/CT PSMA:

- ☐ **F-18 Pylarify** (Head to Toe - A9595)
- ☐ **Ga-68 Illuccix** (Head to Toe - A9596)
- ☐ **F-18 Posluma** (Head to Toe - A9608)

☐ Intial Treatment Strategy
(Includes Diagnosis and Initial Staging)

☐ Subsequent Treatment Strategy
(Includes Treatment Monitoring, Restaging and Detection of Recurrence)

Is the patient a diabetic? ☐ Yes ☐ No If yes, ☐ Oral ☐ Insulin

Possibility of pregnancy? ☐ Yes ☐ No Breast feeding? ☐ Yes ☐ No

Claustrophobic? ☐ Yes ☐ No

Is the patient currently receiving ***Neupogen*** or ***Neulasta***?
(Patient needs to be off GCSF for a minimum of 2 weeks prior to PET/CT (> 4 weeks is suggested). ☐ Yes ☐ No

Please include the following reports if applicable.

☐ Biopsy or Surgery Report Date_____ Where_____
PET/CT 6-8 weeks is optimal after surgery or RFA

☐ CT, MRI or PET/CT scans Date_____ Where_____

☐ Pathology Report Date_____ Where_____

☐ Chemotherapy Date_____ Where_____
PET/CT 4-6 weeks is optimal after chemo

☐ Radiation therapy Date_____ Body Area_____
PET/CT 6-8 weeks is optimal after radiation

☐ Physician Clinical Notes (H & P)

PLEASE SEND ORDER FORM & ALL REPORTS TO CARTI PET/CT UPON SCHEDULING APPOINTMENT