Decatur Health Imaging, LLC
aka OMI Management of Decatur, LLC
1123 16th Avenue SE
Decatur, AL 35601
Phone: (256)350-6364
Fax: (256)351-8436
www.decaturpetct.com

PET/CT EXAM ORDER FORM

Ordering Physician:	**Order Date:**

PATIENT INFORMATION				
Patient's Name:		**SSN:**		
Pt Phone #:	**DOB:**	**M**_____ **F**_____	**Height:**	**Weight:**
Diabetic? Yes_____ **No**_____		**Drug Allergies:**		
Date of Scheduled Exam:		**Time:**		

DIAGNOSIS:	**ICD-10 CODE:**

TYPE OF PET/CT EXAM		
Select Requested Exam:	**Initial Treatment Strategy:**	**Subsequent Treatment Strategy:**
☐ Whole Body PET/CT (skull base to mid-thigh)	☐ Diagnosis	☐ Restaging
☐ Whole Body PET/CT (DX: Melanoma Only)	☐ Staging	☐ Recurrence
☐ AXUMIN™ (fluciclovine F 18)		☐ Response to Therapy
☐ BRAIN SCAN for: ☐ Tumor ☐ Dementia		
☐ Radiation Treatment Planning - Please provide pictures if available. If applicable, list positioning preference and positioning device _____		

Prior PET Scans Date:	Location:
Prior CT Scans Date:	Location:

TREATMENT HISTORY		
SURGERY:	CHEMO:	XRT:
NEUPOGEN/NEULASTA (GCSF):_____ (should be off >3 wks to evaluate skeletal lesions)		

INSURANCE INFORMATION	
Patient Insurance Company:	
Policy #:	Pre-Authorization #:
Insurance Company Phone #:	Representative:
Please Fax Demographics and Insurance Information with Order: (256)351-8436	

PHYSICIAN SIGNATURE (REQUIRED):_____