Shields PET/CT

Amyloid PET/CT Written Order Form
To schedule PET/CT studies please
Call: 1-866-258-4PET (4738) or
Fax: 1-617-603-8004

- ☐ **BOSTON, MA at TUFTS MEDICAL CENTER** Tax ID#: 80-0715912
- ☐ **EMERSON HOSPITAL** Tax ID#: 85-2016078
- ☐ **FITCHBURG, MA** Tax ID#: 04-3454298
- ☐ **FRAMINGHAM, MA** Tax ID#: 80-0715912
- ☐ **HARWICH, MA** Tax ID#: 26-3892846
- ☐ **NEWBURYPORT, MA at ANNA JAQUES HOSPITAL** Tax ID#: # 38-3989358
- ☐ **NORTHAMPTON, MA at COOLEY DICKINSON HOSPITAL** Tax ID#: 36-4827495
- ☐ **PITTSFIELD, MA at BERKSHIRE MEDICAL CENTER -HILLCREST CAMPUS** Tax ID#: 36-4872927
- ☐ **SANDWICH, MA** Tax ID#: 26-3892846
- ☐ **SPRINGFIELD, MA** Tax ID#: 04-3454301
- ☐ **SOUTHBRIDGE, MA at HARRINGTON HOSPITAL** Tax ID#: 04-3454298
- ☐ **WEYMOUTH, MA at SOUTH SHORE HOSPITAL** Tax ID#: 04-3548940
- ☐ **WORCESTER, MA** Tax ID#: 04-3454298

MAINE

- ☐ **LEWISTON, ME at CENTRAL MAINE MEDICAL** Tax ID#: 30-0952705
- ☐ **WELLS, ME at YORK HOSPITAL IN WELLS** Tax ID#: 81-5066570

*PATIENT INFORMATION**

Patient Name: _____ DOB: _____

Weight: _____ Height: _____ Phone: _____ Cell: _____

Insurance Co: _____ Subscriber ID: _____

Authorization: _____ Valid Dates: _____ Translation Services Needed? *YES* *NO*

Requested Procedure:

78814 – Amyloid Brain* (If no tracer preference is selected, the most available option will be provided)

- ☐ Amyloid Neuraceq
- ☐ Amyloid Amyvid

Amyloid-specific information <u>required to accompany this order</u>:

- ☐ **Any imaging reports previously completed (PET/CT scans, CT scans, MRI scans, Brain scans)**
- ☐ **A copy of Mini-Mental State Examination (MMSE) score or similar test**
- ☐ **Any History and Physical (H&P) exams (including medical history and current list of medications)**

Diagnosis (ICD-10 codes)*: _____

Facility location of previous CT/MRI: _____

REFERRING PHYSICIAN INFORMATION

Physician's Signature*:_____ Phone #:_____

Physician's Name (please print): _____ Fax #:_____

Physician's NPI: _____ Appointment Date:_____ Time:_____

By signing this request form, I acknowledge full responsibility for the information that must be completed and maintained in this patient's medical record in my office. I have verified that all conditions described above have been met. Upon request I will make this documentation available to the provider and/or to CMS, its agents or other authorized personnel for review.

PLEASE HAVE PATIENT BRING ANY PREVIOUS CT, MRI, PET FILMS WITH THEM TO THEIR APPOINTMENT.

Lines with an asterisk* are required in order to refer patient