Pylarify (F-18 PSMA) PET/CT REFERRAL DATA SHEET

Center for Molecular Imaging and Therapy

Please note new location and contact information for CMIT

2120 Kings Highway
Scheduling: 318-716-4001
Fax: 318-716-4075

PATIENT NAME: _____
print

PHYSICIAN: _____ _____
print signature of referring physician

PRIORITY (check one):
_____ **ROUTINE (for restaging and follow up scans)**
_____ **ASAP (for staging, treatment or surgery planning)**
_____ **SPECIFIC DATE**: _____

DIAGNOSIS: Prostate Cancer Date of diagnosis**:** _____

Prior treatment:

Surgery:	Yes / No	Date: _____
Radiation:	Yes / No	Date: _____
Chemotherapy:	Yes / No	Date: _____
Hormonal:	Yes / No	Date: _____
Other:	Yes / No	Date: _____

REASON FOR SCAN
(DESIRED INFORMATION): _____

Current PSA: _____ Date: _____
Prior PSA: _____ Date: _____

PLEASE FAX CLINICAL DOCUMENTATION DETAILING PRIOR WORKUP AND MANAGEMENT INCLUDING PRIOR SCANS & LABS

ICD 10 (Please check all that apply)

___	**C61**	**Malignant neoplasm of prostate**
___	**C79.82**	**Secondary malignant neoplasm of genital organs (must be accompanied by C61)**
___	**Z19.1**	**Hormone sensitive malignancy**
___	**Z19.2**	**Hormone resistant malignancy**
___	**Z85.46**	**Personal history of malignant neoplasm of prostate (must be accompanied by C51 or R97.21)**
___	**R97.21**	**Rising PSA following treatment for malignant neoplasm of prostate**

I verify that this office has used Appropriate Use Criteria before ordering this PET/CT Scan: ☐ Yes ☐ No

This office has requested pre-authorization for CPT 78815 and HCPCS A9595. ☐ Yes ☐ No

In order to provide you with the maximum possible information from your patient's PET/CT scan, it is critical that the clinical data on this form be available to the physician at the time of the study. It should be supplemented with copies of an appropriate history and physical or clinical notes, copies of recent diagnostic imaging reports and relevant laboratory data (e.g. tumor marker levels), as well as results of recent biopsy or surgical pathology. **Patients cannot be scheduled without the information on this form being complete and signed by the referring physician (required by CMS (Medicare) and private insurance carriers).**

Person faxing information: _____ **Phone** _____