FLORIDA CANCER SPECIALISTS & Research Institute

(855) 271-8071 • Fax: (855) 314-6973

Patient Name _____ Date Ordered _____

Address _____

SSN _____ M / F DOB _____ Phone _____

Insurance Provider _____ Insurance ID# _____

Prior Scan ☐ Yes ☐ No *(If patient had prior scan, please attach)*

PLEASE ATTACH COPY OF INSURANCE CARDS & RECENT OFFICE VISIT NOTE WITH THIS FORM

Requested Date of Exam _____ ICO-10 Code _____

Reason for Exam _____

This diagnostic imaging requires auc documentation: AUC/CDS modifier _____

CDSM consulted _____

Access to AUC tool: **openaccess.careselect.org/registration**

PET/CT SCAN: Please select ☐ Initial Treatment Strategy ☐ Restaging

☐ Skull Base to Mid-Thigh

☐ Whole Body (For Melanoma, Multiple Myeloma, Merkel Cell)

☐ Axumin Skull to Mid-Thigh

☐ Detectnet (Cu64) Scan

☐ NAF-18 (Bone) Scan Whole Body

☐ Pylarify - PSMA (Certain Locations)

CT SCAN: All CT scans require a Creatinine and EGFR level within the last 30 days for patients 60 and over

☐ Abdomen
☐ With ☐ W/O ☐ With & W/O

☐ Cervical Spine
☐ With ☐ W/O ☐ With & W/O

☐ Chest, Abdomen, Pelvis
☐ With ☐ W/O ☐ With & W/O

☐ Maxillofacial
☐ With ☐ W/O ☐ With & W/O

☐ Thoracic Spine
☐ With ☐ W/O ☐ With & W/O

☐ Abdomen Triple Phase W Pelvis W Contrast
☐ With & W/O

☐ Abdomen, Pelvis
☐ With ☐ W/O ☐ With & W/O

☐ Chest
☐ With ☐ W/O ☐ With & W/O

☐ Lower Extremity
☐ With ☐ W/O ☐ With & W/O
☐ Left ☐ Right ☐ Upper
☐ Lower ☐ Both

☐ Neck
☐ With ☐ W/O ☐ With & W/O

☐ Upper Extremity
☐ With ☐ W/O ☐ With & W/O
☐ Left ☐ Right ☐ Upper
☐ Lower ☐ Both

☐ Brain
☐ W/O ☐ With & W/O

☐ Chest, Abdomen
☐ With ☐ W/O ☐ With & W/O

☐ Lumbar Spine
☐ With ☐ W/O ☐ With & W/O

☐ Pelvis
☐ With ☐ W/O ☐ With & W/O

☐ Abdomen Triple Phase
☐ With & W/O

ALLERGY TO IODINE ☐ Yes ☐ No Allergy Med Given: _____

Referring Physician Name_____ Phone #_____

Signature _____ Fax # _____