CereScan®

PROVIDERS: Please fill out this form and fax it to (866) 433-3965 before giving a copy to the patient.

BRAIN IMAGING:

EXAM:

- ☐ Brain SPECT (78607)
- ☐ Brain SPECT w/ CT (78607/70450)
- ☐ DaTscan SPECT (78607)
- ☐ Brain PET/CT (78608)

INDICATION *(Check all that apply)*:

- ☐ ADD-ADHD (F90.9)
- ☐ Alzheimer's disease (G30.9)
- ☐ Anxiety Disorder (F41.9)
- ☐ Ataxia (R27.0)
- ☐ Bipolar Disorder (F31.9)
- ☐ Depression (F32.9)
- ☐ Mild Cognitive Impairment (G31.84)
- ☐ Parkinsonian (G20)
- ☐ Toxic Encephalopathy (G92)
- ☐ TBI (S06.2X0A)
- ☐ TBI with LOC (S06.2X9A)
- ☐ PTSD (F43.10)
- ☐ Seizure (G40.89)
- ☐ Stroke
- ☐ Other:_____

HISTORY / MEDICAL NECESSITY:

_____

_____

_____

_____

_____

PET/CT IMAGING:

EXAM:

- ☐ FDG Skull to Thigh (78815)
- ☐ FDG Whole Body (78816)
- ☐ FDG Limited Area (78814)
- ☐ F-18 Bone Scan (78816)

GENERAL NUCLEAR MEDICINE:

EXAM:

- ☐ Whole Body Bone Scan (78306)
- ☐ 3 Phase Bone Scan (78315)
- ☐ Limited Bone Scan (78300)
- ☐ SPECT Bone Scan (78320)
- ☐ HIDA Scan (78227)

PATIENT INFORMATION:

Name

Date of Birth *Female/Male*

Home Phone # *Alternate Phone #*

Parent/Guardian (if patient is a minor)

Height *Weight*

Email

How would the patient like to receive their scan results?
☐ EMAIL ☐ FAX ☐ MAIL (hard copy)

ORDERING PROVIDER:

Name *NPI*

Clinic Name

Specialty

Phone # *Fax #*

Email

Address

Address 2

City *ST* *Zip*

How would you like to receive the patient's scan results?
☐ EMAIL ☐ FAX ☐ MAIL (hard copy)

Signature *Date*