



NILES IMAGING
 8915 W Golf Rd
 Niles, IL 60714
 P: 847-827-9060
 F: 847-827-7196



AXUMIN PET SCAN REQUEST FORM

Patients referred to undergo Axumin PET/CT scans will have their scans completed within 1-4 business days following the receipt of this request form. This scheduling timeline allows us to obtain insurance verification, authorizations & financial support for eligible patients. Scheduling may be delayed if there are any problems with this process.

Requesting Physician: _____ **Date:** _____

Contact Person: *(Physician's Office)* _____ **Phone #:** _____

Patient Name: _____ **DOB:** _____

Diagnoses & Clinical Criteria:

Primary:
 C61 – Prostate Cancer (Recurrence)

Secondary: *(please specify secondary diagnoses)*
 Serial rises in PSA
 Other: _____

Diabetic: Yes No.
 Medications: _____
 Special Assistance Required:
 Yes: _____ No

Clinical Criteria: *(please specify applicable criteria)*
 Prostatectomy done
 Approximate date: _____
 PSA >2ng/ml
 Consecutive rises in PSA (at-least 2 values)
 CT Scan done:
 Negative for metastatic disease
 Bone Scan done:
 Negative for metastatic disease

Scan Requested: AXUMIN (F18 – Fluciclovine) PET/CT Scan (A9588 + 78815)

Please fax this AXUMIN (F18 Fluciclovine) PET/CT Request form and the below information to 847-240-0622:

(Attn: Rosse Garcia – Office Phone: 847-585-7069)

- | | |
|--|--|
| <input type="checkbox"/> Demographics/Face Sheet | <input type="checkbox"/> Original pathology report <i>(for prostate cancer)</i> |
| <input type="checkbox"/> HMO referrals <i>(if needed)</i> | <input type="checkbox"/> Progress Note(s) <i>(Last 2 visits in past 12 months)</i> |
| <input type="checkbox"/> Imaging Order (Requisition Form) | <input type="checkbox"/> Scan Results: <i>(within the last 12 months)</i> |
| <input type="checkbox"/> Insurance Card <i>(front and back)</i> | • Last CT scan, last bone scan |
| <input type="checkbox"/> Lab Results: <i>(within the last 12 months)</i> | <input type="checkbox"/> Others: _____ |
| • Last two (2) PSA results | _____ |
| <input type="checkbox"/> Medication & Allergies List | _____ |

For any insurance/authorization/financial assistance related questions, please ask for our Patient Benefits Counselors

To Be Completed by ICS Staff

<u>Appointment Date & Time:</u>	<u>Patient Notified:</u>