NORTHERN CALIFORNIA
PET Imaging Center

3195 Folsom Boulevard
Sacramento, CA 95816-5233

Phone: 916-737-3211 or 888-PET-3211 (888-738-3211)
Fax: 916-737-6203

REQUEST FORM

FDG PET BRAIN SCAN - DEMENTIA

EXAM DATE: _____ **TIME:** _____

INTRODUCING:

Patient Name: _____

DOB: _____ - _____ - _____

Height: _____ Weight: _____

Diabetic: ☐ Yes ☐ No Claustrophobic: ☐ Yes ☐ No

Street Address: _____ City, Zip: _____

Phone: Hm _____ Wk _____ SSN: _____ - _____ - _____

INSURANCE *(**FAX** copy of front and back of card)* ******Medicare*** *patients – please see below***

Primary: _____ Policy #: _____ Auth #: _____

Secondary: _____ Policy #: _____ Auth #: _____

REFERRING

Physician: _____ Ph: _____ Fax: _____

Contact Name/Phone: _____

Copy To: _____ Fax: _____

In order for a **Medicare** patient to be eligible for a FDG-PET brain scan, certain conditions must be met and verified. Please read the following criteria, complete the form, and sign on the indicated line below.

CLINICAL INDICATION / HISTORY

Medicare covers FDG PET scans for the differential diagnosis of frontotemporal dementia (FTD) and Alzheimer's Disease (AD) under specific requirements. It is considered reasonable and necessary in patients with a recent diagnosis of dementia and documented cognitive decline of **at least 6 months**, aided by cognitive scales or neurophysiologic testing, laboratory tests and structural imaging; i.e. MRI or CT.

Has a brain SPECT or FDG-PET scan been obtained for the same indication? ☐ yes ☐ no

Were the results inconclusive? ☐ yes ☐ no

(FDG PET may be repeated <u>one year</u> after inconclusive SPECT or PET. *It may be repeated sooner if there is a change in diagnosis*)

Date of Onset of Symptoms _____

Diagnosis of Clinical Syndrome ☐ normal aging ☐ mild cognitive impairment (MCI) ☐ other _____

☐ mild dementia ☐ moderate dementia ☐ severe dementia

Presumptive cause ☐ possible AD ☐ probable AD ☐ uncertain AD

*Attach **(fax to 737-6203)** Results of the Following*

Mini Mental Status Exam (MMSE) or similar? test score _____

Neuropsychological Testing? ☐ yes ☐ no

Structural Imaging (CT/MRI)? ☐ yes ☐ no

Relevant Lab Tests (B12, thyroid hormone)? ☐ yes ☐ no

Prescribed Medications? ☐ yes ☐ no Name(s) _____

_____

_____

Brief Clinical History: _____

_____

SIGNATURE of Referring Physician: _____ **Date:** _____

(Required)