CancerCare NORTHWEST

PSMA PET/CT Scan
Patient Referral Form

Date: _____

PATIENT INFORMATION

_____ _____
Last Name, First Name Date of Birth

_____ Cell
Contact Number

EXAM

Requested Exam:

☐ PSMA PET/CT Scan

Reason for Request:

☐ C61 Active prostate cancer (Suspected Metastasis)
☐ Z85.46 History of prostate cancer (Suspected Recurrence)
**will require rising PSA to qualify for test*
☐ R97.21 Rising PSA following treatment for prostate cancer

ORDERING PROVIDER INFORMATION

_____ _____
Name of Ordering Provider Name of Clinic

_____ _____ _____
Ordering Provider Signature Phone Number Fax Number

REFERRING PHYSICIAN CHECKLIST

☐ Patient demographic information
☐ Copy of insurance card(s) (front and back)
☐ Patient chart notes
☐ Insurance authorization *# (if required):*
_____
☐ Last 2 PSA results

Please fax this referral form and the medical information listed above to (509) 252-9337.
Thank you for your referral.

*Questions? Please call the **PSMA PET/CT Patient Coordinator @ (509) 228-1557**.*