

Pre-PET Form

National Oncologic PET Registry

- You have requested a PET scan for an indication for which the Centers for Medicare and Medicaid Services (CMS) requires pre- and post-PET information prior to approving the study for reimbursement. In order for the imaging center to be reimbursed this form must be completed and returned to the PET facility before the PET scan is performed. You also will be sent by e-mail and required to complete a follow-up form about one week after the PET scan is done. Thank you for your assistance completing the brief pre- and post-PET forms.
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PET Facility ID #: _____ Registry Case #: _____

PATIENT INFORMATION

Date: ____/____/____

First Name: _____ Last Name: _____

Date of Birth ____/____/____

SSN#: _____

REFERRING PHYSICIAN

First Name: _____ Last Name: _____

Office Telephone: (____) _____ Office Fax: (____) _____

Your preferred E-mail Address: _____

Comment to Clinician: The follow-up questionnaire will be sent to you by e-mail.

1. SPECIFIC REASON FOR PET STUDY

a. Check the single best match for the reason for the PET (*you must check only one of the following and then answer the section(s) indicated for question 2*)

- Diagnosis:** To determine if a suspicious lesion is cancer (answer 2a and 2b)
- Diagnosis/Unknown Primary Tumor:** To detect a primary tumor site in a patient with a confirmed metastatic lesion (answer 2c)
- Diagnosis/Paraneoplastic:** To detect a primary tumor site in a patient with a presumed paraneoplastic syndrome (answer 2a and 2b)
- Initial Staging** of histologically confirmed, newly diagnosed cancer (answer 2a and 2b)
- Monitoring Treatment Response** during chemotherapy (answer 2a and 2b)
- Monitoring Treatment Response** during radiation therapy (answer 2a and 2b)
- Monitoring Treatment Response** during combined modality therapy (e.g., chemo ± radiation ± surgery ± biologic therapy) (answer 2a and 2b)
- Restaging** after completion of therapy (answer 2a and 2b)
- Suspected Recurrence** of a previously treated cancer (answer 2a and 2b)

2. CANCER TYPE AND WORKING STAGE

- For a patient with a known primary or clinically suspected cancer, please mark the corresponding box of the cancer type in section 2a and answer question 2b. For a patient with metastatic disease of unknown primary origin, mark the corresponding box of the site of metastatic disease in section 2c. If your patient's cancer is not listed, check the Other box and enter as text the cancer type.
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a. Cancer Type (ICD-9 Code) - check the one cancer that most closely relates to the specific reason for the PET study indicated in response to Question 1. (Check only one)

- | | |
|---|---|
| <input type="checkbox"/> Lip, Oral Cavity, and Pharynx (140-149) | <input type="checkbox"/> Melanoma of skin (172) |
| <input type="checkbox"/> Esophagus (150) | <input type="checkbox"/> Female breast (174) |
| <input type="checkbox"/> Stomach (151) | <input type="checkbox"/> Male breast (175) |
| <input type="checkbox"/> Small Intestine (152) | <input type="checkbox"/> Kaposi's sarcoma (176) |
| <input type="checkbox"/> Colon (153) and Rectum (154) | <input type="checkbox"/> Uterus, unspecified (173) |
| <input type="checkbox"/> Anus (154) | <input type="checkbox"/> Cervix (180) |
| <input type="checkbox"/> Liver and intrahepatic bile ducts (155) | <input type="checkbox"/> Uterus, body (183) |
| <input type="checkbox"/> Gallbladder & extrahepatic bile ducts (156) | <input type="checkbox"/> Ovary and uterine adnexa (183) |
| <input type="checkbox"/> Pancreas (157) | <input type="checkbox"/> Prostate (185) |
| <input type="checkbox"/> Retroperitoneum and peritoneum (158) | <input type="checkbox"/> Testis (186) |
| <input type="checkbox"/> Nasal cavity, ear, and sinuses (160) | <input type="checkbox"/> Penis and other male genitalia (187) |
| <input type="checkbox"/> Larynx (161) | <input type="checkbox"/> Bladder (188) |
| <input type="checkbox"/> Lung, non-small cell (162) | <input type="checkbox"/> Kidney and other urinary tract (189) |
| <input type="checkbox"/> Lung, small cell (162) | <input type="checkbox"/> Eye (190) |
| <input type="checkbox"/> Pleura (163) | <input type="checkbox"/> Primary Brain (191) |
| <input type="checkbox"/> Thymus, heart, mediastinum (164) | <input type="checkbox"/> Thyroid (193) |
| <input type="checkbox"/> Bone/cartilage (170) | <input type="checkbox"/> Lymphoma (200-202) |
| <input type="checkbox"/> Connective/other soft tissue (171) | <input type="checkbox"/> Myeloma (203) |
| <input type="checkbox"/> Leukemia (204-208) | |
| <input type="checkbox"/> Other or not listed. Please describe cancer type _____ | |

b. Has this cancer diagnosis been pathologically proven? Yes No

c. Unknown primary: site of pathologically proven metastatic disease (196-199)

- | | |
|---|---|
| <input type="checkbox"/> Lymph node(s) | <input type="checkbox"/> Brain |
| <input type="checkbox"/> Lung | <input type="checkbox"/> Bone/bone marrow |
| <input type="checkbox"/> Liver | |
| <input type="checkbox"/> Other. Specify _____ | |

3. YOUR WORKING SUMMARY STAGE FOR THE PATIENT BEFORE THE PET SCAN IS?

(you must check only one)

- No evidence of disease / In remission
- Localized only
- Regional by direct extension or lymph node involvement or both
- Metastatic (distant) with a single suspected site
- Metastatic (distant) with multiple suspected sites
- Unknown or uncertain

4. PATIENT PERFORMANCE STATUS

a. Check the box best describing your patient's global functional status (ECOG Performance Score) (you must check only one)

- (0) Asymptomatic: *fully active, able to carry on all activities without restriction.*
- (1) Symptomatic, fully ambulatory: *restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature.*
- (2) Symptomatic in bed <50% of the day: *ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.*
- (3) Symptomatic in bed >50% of the day, but not bedridden: *capable of only limited self-care, confined to bed or chair 50% or more of waking hours.*
- (4) Bedridden: *Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.*

5. MANAGEMENT PLAN

a. If PET were not available, your current **management strategy** would be? (you must check only one)

- Observation** (with close follow-up)
- Additional Imaging** (CT, MRI) or other non-invasive diagnostic tests
- Tissue Biopsy** (surgical, percutaneous, or endoscopic).
Note: If concurrent biopsy and total surgical resection are planned, then mark "surgical" treatment below.

Treatment (if treatment is selected, then also complete the following)

Treatment Goal: (check one) Curative Palliative

Type(s): (check all that apply) Surgical Chemotherapy (including biologic modifiers)
 Radiation Other Supportive care

Will treatment be directly provided by you? (check one) Yes No

6. NAME OF PERSON WHO COMPLETED THE PAPER FORM

First Name: _____ Last Name: _____ Date _____

Thank you for your assistance.