Oncology Las Vegas
Physician Family-Owned

PET/CT REFERRAL FORM

Referral intake checklist | Phone: 702-730-2097
Fax: 702-702-9070

Referral Date: _____

Please complete all applicable fields and send supporting records with the referral. Scheduling and coverage are subject to clinical review and payer requirements.

PATIENT INFORMATION

Patient full name: _____ DOB: _____ Sex: _____
Phone: _____ Alternate phone: _____
Address: _____

REFERRING PROVIDER / PRACTICE

Referring clinician: _____ Referring clinician signature: _____
Office contact: _____ Phone: _____ Fax: _____
Ordering clinician NPI: _____ Practice: _____

INSURANCE AND AUTHORIZATION

Primary payer / plan: _____ Member ID: _____
Group #: _____ Secondary payer / ID: _____
Subscriber name / DOB (if different): _____
Prior authorization: ☐ Requested by referring office ☐ Request OLV assistance ☐ Not required / verified
Authorization #: _____ Valid dates: _____ to _____ ☐ Pending

PET/CT ORDER AND CLINICAL INDICATION

Requested exam ☐ SBMT ☐ Wholebody (Melanoma, Cutaneous Lymphoma, Multiple Myeloma)
☐ Illuccix PSMA ☐ Posluma PSMA ☐ Dotatate ☐ Other PET (please specify)_____
☐ Initial staging ☐ Restaging / suspected recurrence ☐ Treatment response ☐ Other: _____
Primary diagnosis: _____ ICD-10: _____
Clinical question / medical necessity: _____
Preferred date / timing: _____ ☐ Urgent (reason): _____

REQUIRED REFERRAL PACKET — CHECK EACH ITEM ENCLOSED

☐ Signed and dated PET/CT order (study, diagnosis, ordering provider)
☐ Patient demographics and current contact information
☐ Front and back of insurance card(s), plus plan / subscriber details
☐ Most recent relevant office / consultation notes documenting medical necessity
☐ Diagnosis and ICD-10 code(s), with reason for the requested PET/CT
☐ Prior authorization approval / reference number, if already obtained

ADDITIONAL CLINICAL DOCUMENTATION — WHEN APPLICABLE / PAYER REQUESTED

☐ Pathology / biopsy report confirming diagnosis, if available
☐ Prior relevant imaging reports (CT, MRI, PET/CT, bone scan, etc.) and comparison dates
☐ Treatment history and dates (surgery, radiation, systemic therapy)
☐ Relevant laboratory results / tumor markers and trends, if used to justify imaging
☐ Prior PET/CT report and reason repeat imaging is needed
☐ Evidence of recurrence, progression, equivocal conventional imaging, or management impact
☐ Payer-specific forms, referral approval, or supporting clinical criteria, if required

OFFICE USE ONLY

Received: _____ Reviewed by: _____ ☐ Complete ☐ Missing items requested
Authorization status: ☐ Not started ☐ Pending ☐ Approved ☐ Denied ☐ Not required
Notes / missing documents: _____
Authorization requirements depend on the payer, plan, diagnosis, tracer, and indication. This checklist does not establish medical necessity or guarantee coverage. Send patient information only by an approved secure method.