

ONCOLOGY CT-MR FAX FORM

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Completing this survey can provide quicker turnaround. Additional comments can be made in the comments section. We encourage you to electronically forward relevant data/notes, especially results of previous imaging. This form and all data submitted are legally considered an extension of the medical record with regard to privacy and accuracy. Any inconsistencies on this survey compared with the office medical record should be explained in the comments section. MedSolutions reserves the right to request detailed information for the patient. Fax forms (non-urgent requests only) to 888.693.3210

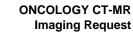
URGENT (Same Day) REQUESTS ARE ONLY ACCEPTED BY PHONE AT 888.693.3211.

Member	Patient First Name:			Patient Last Name:				
	DOB: Member II		D:	Group #:		Health Plan:		
	Address:			City:		ST:	Zip:	
Physician	Physician First Name:			Physician Last Name:				
	Primary Specialty:		NPI:	Tax ID:				
	Address:			City:		ST:	Zip:	
	Phone #: Fax #:			Contact Email:				
Facility	Facility Name:			Facility Tax ID:				
	Address:			City:		ST:	Zip:	
	Phone #:	Fax #:		NPI:	RETRO	Date of Serv	vice:	
	If this request is for a PET or a PET/CT, please use the appropriate PET-CT form available on the portal. List all CPT® code(s) (Required Field): ICD-9 Code (Required Field):							
	Please fill in the following questions; non-applicable questions may be skipped.							
Clinical	Date of the most recent office visit or other documented contact with physician (mm/dd/yyyy) Don't Know							
	2. Has cancer diagnosis been confirmed by biopsy? Yes Date of biopsy which confirmed THIS diagnosis (mm/dd/yyyy) No Don't Know							
	3. What is the cell type and location of primary disease? Cell type: Location: Unknown primary							





	Patient Name:	DOB:	(Page 2 of 3)
4.	If cancer was recently diagnosed, size of primary tumor		
	☐ Don't know		
5.	Is there known metastatic disease? (Metastatic disease = tumor cells have s Yes No Don't know	spread to other parts of the body)	
6.	Please choose the correct response in regards to resection of this cancer. Resection not appropriate or is not feasible Resection was done and removed all known tumor Resection did not remove all known tumor Resection is planned following this imaging Don't know.		
7.	Is this a recurrent disease? No, this is not a recurrence Yes, Date of THIS recurrence (mm/dd/yyyy) Don't know		
8.	Was the individual recently (within last 3 months) treated with chemotherapy that apply) No chemotherapy in last 3 months Chemo is currently on-going Chemotherapy completed within the last 3 months Chemotherapy is planned Don't know.	and/or is chemotherapy planned s	soon? (Choose all
9.	Has a course of radiation therapy been completed or is planned? No radiation Radiation finished less than 90 days ago Radiation finished more than 90 days ago Radiation is planned in the future Radiation is on-going Don't know		
10.	Is a tumor marker (PSA, CEA, etc.) test elevated with documented rising from No Yes Don't know	n the previous level?	
11.	Currently, are there new signs or symptoms suggesting progression of disease Yes, symptoms are worrisome for progression of disease Yes, there are objective signs on the physical examination Yes, there are both signs and symptoms No, there are no current signs or symptoms Don't Know	se?	





	Patient Name:	DOB:	(Page 3 of 3)
	12. Is the requested study for the evaluation of abnormalities seen on No No Yes (please provide date and type of previous imaging) Date of previous imaging (mm/dd/yyyy) Type of previous imaging (US, CT, MRI, etc.) Don't Know Who will be the responsible contact for additional information, if needed Print Name: Additional Information/Comments:	previous imaging? d, concerning this request?	(Page 3 of 3)
Submitter	Check the appropriate box describing you: Ordering Physician Sign and Date Below: Responsible Contact: Print Name:	_	