United Theranostics Chesapeake

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Consultation Referral for Prostate:

☐ Prostate (Pluvicto®) Radiopharmaceutical Therapy includes dosimetry calculations after each treatment cycle to determine radiation uptake of the healthy organs which includes a SPECT/CT (initial uptake), a second SPECT CT (early decay), and a 3rd SPECT CT (late decay). A dosimetry report will be provided.

☐ Prostate radiopharmaceutical treatment only. (Requires physician to physician consult to discuss risks)

Consultation Referral for Neuroendocrine:

☐ Neuroendocrine (Lutathera®) Radiopharmaceutical Therapy includes dosimetry calculations after each treatment cycle to determine radiation uptake of the healthy organs which includes a SPECT/CT (initial uptake), a 2nd SPECT CT (early decay), and a 3rd SPECT CT (late decay). A dosimetry report will be provided.

☐ Neuroendocrine radiopharmaceutical treatment only. (Physician consult required to discuss risks)

Consultation Referral for Thyroid:

☐ Thyroid (I-131) Radiopharmaceutical Therapy includes +/- Thyrogen + imaging dose I-131 or I-123 + 1-3 pretreatment SPECT/CT's +/- Thyrogen + either low dose or high dose I-131 treatment + 1-3 SPECT/CT's for dosimetry + blood draw + follow-up visit (the "I-131 Cycle"). Dosimetry report will be provided.

☐ I-131 radiopharmaceutical treatment only. (Requires physician to physician consultation to discuss risks)

Consultation Referral for XoFigo®:

☐ Bone Metastases Radiopharmaceutical Therapy (Xofigo®)

Diagnostic Imaging:

PET/CT

☐ Prostate (PSMA)
☐ Neuroendocrine (DOTATATE)
☐ Brain
☐ Breast (Cerianna)
☐ Malignancy (FDG)
☐ Infection (FDG)
☐ Inflammation (FDG)
☐ Cardiac

SPECT/CT

☐ Bone (MDP)
☐ Renal (MAG3 or DTPA)
☐ Adrenal Imaging (MIBG)
☐ Hepatobiliary
☐ Cardiac EF (MUGA)

TO EVALUATE _____

Diagnostic CT Scan (Body Part) _____

Patient Information:

Patient Name _____ DOB _____

Address _____

City/State/Zip _____ Primary Phone # _____

DPOA or Legal Guardian Name _____ Primary Phone # _____

Referring Physician Information:

Referring Physician/Advanced Practice Provider's Name _____

NPI # _____ Clinic Name _____

Clinic Contact Name _____ Phone Number _____

Signature _____

Please Note: Our team will obtain the prior authorization and discuss coverage with your patient. We will contact your clinic for the patient's records as we need them.

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