

**Georgia Department of Community Health**

**Position Emission Tomography (PET) Services Survey Parts A-D**

**for 1/1/2006-12/31/2006**

**UID:**

**Part A: General Information**

Due Date: July 20, 2007

Year: 2006

**1. Identification:**

Facility UID	<input type="text"/>				
a. Facility Name	<input type="text"/>	b. County	<input type="text"/>		
c. Street Address	<input type="text"/>	d. City	<input type="text"/>	e. Street Zip	<input type="text"/>
f. Mail Address	<input type="text"/>	g. City	<input type="text"/>	h. Mail Zip	<input type="text"/>
i. Medicaid Provider Number	<input type="text"/>	j. Medicare Provider Number	<input type="text"/>		

**2. Report Period:**

Report data for the full 12-month period, January 1, 2006 through December 31, 2006 (365 days). Do not use a different report period.

Check the box to the right if your facility was not operational for the entire year

If your facility was not operational for the entire year, provide the dates the facility was operational below:

**Part B: Survey Contact Information**

Person authorized to respond to inquiries about the responses to this survey:

Name	<input type="text"/>	Title	<input type="text"/>		
Telephone:	<input type="text"/>	Fax	<input type="text"/>	E-mail	<input type="text"/>

**Part C: Ownership and Organizational Structure**

1. OWNERSHIP, OPERATION AND MANAGEMENT as of the last day of the Report Period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the Organization Type. If the category is not applicable, the form requires you only to indicate "Not Applicable" in the Legal Name column. You must enter some response in each category.

Category	Full Legal Name (or "Not Applicable")	Organization Type	Effective Date
a. Facility Owner:	<input type="text"/>	<input type="text"/>	<input type="text"/>
b. Owner's Parent Org:	<input type="text"/>	<input type="text"/>	<input type="text"/>
c. Facility Operator:	<input type="text"/>	<input type="text"/>	<input type="text"/>
d. Operator's Parent Org:	<input type="text"/>	<input type="text"/>	<input type="text"/>
e. Mgmt. Contractor:	<input type="text"/>	<input type="text"/>	<input type="text"/>
f. Mgmt's Parent Org:	<input type="text"/>	<input type="text"/>	<input type="text"/>

2. Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period.

If checked, please explain in the box below and include effective dates.

**Part D: PET Imaging Services Technology and Volume by Diagnostic Type**

**Manufacturer and Model:**

1. Please document the manufacturer and model of PET equipment and select PET only or PET/CT Hybrid Unit.  
NOTE: If you have more than one scanner, please complete one survey for each machine.



2. Please report the patients and scans for PET imaging services during the reporting period by the patient's primary diagnostic area. Please provide unduplicated patient counts within each of the three subgroups. The sum total of all patients for all three diagnostic areas (automatically calculated by the database) may include some duplication.

<b>Diagnostic Area Oncology Patients</b>	<b>Number of Patients</b>	<b>Number of Scans</b>
a. Lung and Bronchus Cancers	0	0
b. Colon and Rectal Cancers	0	0
c. Lymphoma Cancers	0	0
d. Melanoma Cancers	0	0
e. Esophageal Cancers	0	0
f. Head and Neck Cancers	0	0
g. Breast Cancers	0	0
h. Other Cancers	0	0
<b>Oncology (Total)</b>	<b>0</b>	<b>0</b>

<b>Cardiovascular Patients</b>	0	0
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**Neurology Patients**

a. Dementias (including Alzheimer's)	0	0
b. Other Neurological Use	0	0
<b>Neurology (Total)</b>	<b>0</b>	<b>0</b>

Other Diagnostic Areas	0	0
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<b>Total (All Services)</b>	<b>0</b>	<b>0</b>
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**Georgia Department of Community Health**

**Position Emission Tomography (PET) Services Survey Parts E-G**

**for 1/1/2006-12/31/2006**

**UID:**

**Year:**

Facility UID

Facility Name

**Part E: PET Services Financial Summary and Patient Demographics**

1. Please report the total number of patients (unduplicated) receiving PET services by primary payment source.

Number of Patients	Payment Source				Total
	Medicare	Medicaid	Third-Party	Self-Pay	

2. Report the Total Charges and Adjusted Gross Revenues for PET services.

Total Charges	Adjusted Gross Revenue

3. Provide the total amount of uncompensated PET services charges that can be attributed to persons who are indigent or eligible for charity care. Also provide the number I/C patients in PET program.

**A. Charges**       **B. Patients**

4. What is your program's average charge for a PET scan or study (one patient visit regardless of number of images)?

5. Please report the number of patients served during the entire report period by the following race and ethnicity categories.

American Indian/ Alaska Native	Asian	Black/ African American	Hispanic or Latino	Hawaiian/ Pacific Islander	White	Multi-Racial	Total

6. Please report the number of patients served during the entire report period by the gender and age grouping below.

	Age of Patient					Total
	Ages 0-14	Ages 15-64	Ages 65-74	Ages 75-85	Ages 85 and Up	
Male						
Female						

7. Does your facility/service participate in and report to the State Cancer Registry?   
(check box fo YES, leave unchecked for NO)

8. Please indicate the days and hours of operation for your program's PET services?

Days PET Services Provided (check all that apply)    **M**   **T**   **W**   **Th**   **F**   **Sat**   **Sun**  
                 

Hours of Operation:  until

**Part F: Mobile Pet Services**

**If your PET service is a mobile provider please check box to the right and complete information below.**   

Please report each location served during the reporting period and the number of days of service provided at each location for each month. If your PET service is fixed-based, continue with Part G. To delete a row, press ESC to clear data entry errors. Then click in the margin to the left of the site name and press the delete key.

**Part G: Patient Origin Table (Must be completed by all providers.)**

Please report the county of origin for patients served by your PET program during the report period. To delete a row, press ECS to clear data entry errors. Then click in the margin to the left of the site name and press the delete key.

**Note to Mobile PET Providers: You must complete this section for every site visit location. Please select from the list of site visit location(s) provided above.**

**MOBILE PROVIDERS must place a check in the check-box in part F before completing part G.**

**Total Patients Served**

**NOTE: You must go to the Signature Form and sign your survey before submitting it. The survey will not be deemed complete without an authorized signature.**

UID:

*Georgia Department of Community Health*

**YOU MUST CHECK FOR ERRORS BEFORE ENTERING THE SIGNATURE**

In order to ensure that the Signature Form will accept the authorized signature below you must first click the "View Error Messages" button. This button will produce a report detailing any missing data items that are required or balances that do not agree, but are required to be in balance. The Signature Form WILL NOT accept an authorized signature until each item on the Data Validation Report is corrected. After correcting errors, click the "View Error Messages" button again to make sure that the errors have been cleared.

**Electronic Signature**

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or inaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature:

Date:

Title:

Comments:

**Unresolved Data Issues**

Please explain any unresolved data issues in the comments box.