

# Survey Registration

## Respondent Information

**Identification #:** 123456

**Facility:** \*TEST SITE\*

**Survey:** PET

**Survey Year:** 2024 ▼

**Respondent First Name:**  \*

**Respondent Last Name:**  \*

**Respondent Phone:**  \*

**Respondent eMail:**  \*

**Respondent Additional eMail:**

**Administrator First Name:**  \*

**Administrator Last Name:**  \*

**Administrator Phone:**  \*

**Administrator eMail:**  \*

**Administrator Additional eMail:**

# 2024 Instructions for Survey

## Positron Emission Tomography

This survey is for the reporting period: January 1, 2024 through December 31, 2024.

**INTRODUCTION:** The Kentucky Annual Survey of Positron Emission Tomography Services is required to be completed and submitted via the internet. The printable version of the survey is only for your convenience in completing the survey on paper before submitting the data online. The accuracy and completeness of the data reported in this survey are essential to the process of health planning in Kentucky. It also represents the data requirements as set forth in 900 KAR 6:125. All items must be completed with actual tabulated data before this survey will be considered acceptable. Surveys are due March 15, 2025. For purposes of this Survey and Service Report you will complete data for the period of January 1, 2024 through December 31, 2024.

**ONLY THE LICENSED PET SERVICE SHOULD COMPLETE THE SURVEY.** For example, if the hospital holds a license for PET services, the hospital completes the survey, not the vendor. If the vendor holds a license for PET services, the vendor completes the survey, not the hospital. All survey extension requests must be approved by the Survey Administrator.

You are responsible for the accuracy of the data reported in this survey. Failure to complete and correct the indicated parts of the survey may result in your facility being reported to the Office of Inspector General Division of Health Care for a possible licensure deficiency. Retain a copy of the completed survey for your files.

If there are any questions concerning the preparation of this survey, please contact the Survey Administrator at (502) 564-5798 or [consurvey@ky.gov](mailto:consurvey@ky.gov). The published KY Annual Survey Reports may be viewed at: <https://chfs.ky.gov/agencies/os/oig/dcn/Pages/annualreports.aspx>.

[Continue](#)

## Survey Administrator Information

Michele Bushong  
Cabinet for Health and Family Services  
(502) 564-5798  
[consurvey@ky.gov](mailto:consurvey@ky.gov)

# 2024 Positron Emission Tomography Survey

## PET Service Section

**Identification #:** 123456

**Facility:** \*TEST SITE\*

Definition: Positron Emission Tomography (PET) - Positrons are positively charged electrons that are produced spontaneously as certain radioactive substances (for example, radioactive glucose) decompose. These radioactive substances, or tracers, are created in special facilities called medical cyclotrons. The type of tracer used for a particular PET scan varies, based on the medical condition for which a patient is being tested. The tracers have very short half-lives, which means that they decay rapidly into non-radio-active form. Thus, radioactive material is inside the patient for only a very short time, and the total dose of radiation is equal to and sometimes even less than many other kinds of X-ray procedures. A tomograph is an imaging device, or camera, that obtains sectional views through a patient's body. PET scans combine Nuclear Scanning with chemical analysis to enable physicians to observe how organs work. During a PET scan, a radioactive material is introduced into the patient's body (usually by injection), and is detected by a sophisticated camera.

If less than twelve (12) months of operation, give beginning and ending date(s) in the comment box.  
Hospitals and FMT should report all utilization as Fixed, including relocatable units.

**Total PET Procedures:**

**Mobile:**   
**Fixed:**   
**Total:**

**Total PET Patients:**

**Mobile:**   
**Fixed:**   
**Total:**

Total number of hours per week facility was operational:

Check Service Type:  Freestanding  Mobile  Hospital

(Please check box according to who holds the license. example: a hospital that is licensed to provide PET but uses a mobile should check hospital.)

Hospitals and FMT should report all utilization as Fixed, including relocatable units.

If service was provided by a licensed mobile health service give name of provider:

Number of devices stationed on site:

Hospitals and FMT should report all utilization as Fixed, including relocatable units.

**Mobile:**   
**Fixed:**   
**Total:**

**Comment**

of 255

# 2024 Positron Emission Tomography Survey

## Mobile Positron Emission Tomography Services Section

**\* Page to be completed by mobile units that hold the License to provide the service.**

Mobile units must submit a separate line below for each county and facility served.

\*Number of hours is per week each unit provides service to that facility. Do not include out of state counties.

Facility Served by Mobile PET Units

County	Facility Served	Procedures	Units on Site	Hours Per Week*	Patients Served
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County

Facility Served  \*

# Procedures

# Units On Site

# Hours Per Wk\*

# Patients Served

**\*Do not press the finished button until you have saved your data. Press Add/Save after each new entry. Press Update to save changes for edited item.**

# Positron Emission Tomography Survey for 2024

## Survey Data Verification

Thank you for completing the survey.

On behalf of the administration of \*TEST SITE\*, I certify that the information contained in this report is complete and accurate. After reviewing the information contained in this report, I hereby submit it as an official record of the facility's activity in compliance with 900 KAR 6:125.

**\*Only verify once the survey is completed.\***

Once data is complete, verification notices will be emailed to the state and to your facility's respondent and administrator. If the respondent or administrator does not receive this confirmation it is likely that their email address was not included or had a typo in the registration section of this survey. In this case, please contact Division of CON at consurvey@ky.gov or (502) 564-5798 so this can be corrected.

**Respondent Name:** test test

**Administrator Name:** test test

**Original Completion Date:**

By clicking this button you are indicating that this survey is complete. You will not be able to change any of the data.

[Verify and Submit to State](#)

[Print](#)

## Incomplete Survey(s)

### Facility's Survey(s)

Year	Survey	Equipment	Printable Survey
2024	<a href="#">Ambulatory Surgery II</a>		<a href="#">Print Ambulatory Surgery II</a>
2024	<a href="#">Chemical Dependency</a>		<a href="#">Print Chemical Dependency</a>
2024	<a href="#">Home Health II</a>		<a href="#">Print Home Health II</a>
2024	<a href="#">Hospice</a>		<a href="#">Print Hospice</a>
2024	<a href="#">Hospital</a>		<a href="#">Print Hospital</a>
2024	<a href="#">Long Term Care</a>		<a href="#">Print Long Term Care</a>
2024	<a href="#">Magnetic Resonance Imaging</a>	<a href="#">Equip for MRI</a>	<a href="#">Print Magnetic Resonance Imaging</a>
2024	<a href="#">Megavoltage Radiation (Linear Accelerator)</a>		<a href="#">Print Megavoltage Radiation (Linear Accelerator)</a>
2024	<a href="#">Positron Emission Tomography</a>		<a href="#">Print Positron Emission Tomography</a>
2024	<a href="#">Private Duty Nursing</a>		<a href="#">Print Private Duty Nursing</a>
2024	<a href="#">Psychiatric Residential Treatment Facility</a>		<a href="#">Print Psychiatric Residential Treatment Facility</a>