PET/CT Order Form

Please fill out completely

Date: ____________________

Referring Physician Signature: ____

Contact Person: ______________________ Phone: ______________________

Fax: ______________________

Patient Information:

Last Name: ______________________ First Name: ______________________

DOB: ______________________ SS #: ______________________

Address: ____

City: ______________________ State: ______________ ZIP: ________

Home Phone: ______________________ Work Phone: ______________________

Diagnosis: ______________ ICD-9 Code: __________ Ht: __________ Wt: ________

Reason for study: ❑ Initial treatment strategy (diagnosis or staging)

❑ Subsequent treatment strategy (restaging or monitoring treatment response)

PET or PET/CT scan: ❑ Skull base to mid-thigh ❑ Whole-body ❑ Limited area (chest, H&N)

PET or PET/CT scan: ❑ Brain ❑ Cardiac

Diagnostic CT required? ❑ Yes ❑ No

Diabetic: ❑ Yes ❑ No ❑ Oral ❑ Insulin ❑ Diet

Allergies: ❑ Yes ❑ No If yes, to what: ______________________

Claustrophobic: ❑ Yes ❑ No

Is patient pregnant? ❑ Yes ❑ No

Evidence of abdominal and/or pelvic disease? ❑ Yes ❑ No

Please call us to schedule an appointment

Then, please fax to us the front and back of patient's insurance card, all reports, lab results and notes pertinent to the diagnosis.

Patient is required to bring prior imaging films to their appointment.