

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Patient Phone #: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

Emergency Phone#: \_\_\_\_\_

Patient Weight: \_\_\_\_\_ Patient Height: \_\_\_\_\_ *(If patient weighs over 450 lb, we will be unable to perform the exam.)*

Is the patient in a skilled nursing facility?  Yes  No If yes, name of facility \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Date of scheduled PET/CT scan: \_\_\_\_\_ Time of scheduled PET/CT scan: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

ID/GRP#: \_\_\_\_\_

Name of secondary Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

ID/GRP#: \_\_\_\_\_

**Exam Requested (check one):**     BRAIN     WHOLE BODY

**CHOOSE ONE OPTION:**

<input type="checkbox"/> <b>PET/CT (Standard)</b> <ul style="list-style-type: none"> <li>no separate CT report</li> <li>no oral or intravenous contrast</li> <li>charged as PET only</li> <li>CT evaluation limited by lack of oral &amp; I.V. contrast</li> </ul>	<input type="checkbox"/> <b>PET/CT Plus Full Diagnostic CT scan(s) with oral/I.V. contrast</b> <ul style="list-style-type: none"> <li><b>SPECIFY BODY AREAS REQUESTED FOR CT:</b> _____</li> <li>is patient allergic to iodine (x-ray dye)?    <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>is exam for radiation therapy planning?    <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>patient charged for PET/CT and CT exams</li> <li>separate dictated reports for PET/CT &amp; diagnostic CTs</li> </ul>
--	---

*(Please try to insure that patients blood glucose is in normal range for the best results.)*

Diagnosis: \_\_\_\_\_

**PLEASE NOTE:** It is very important that we have all outside imaging tests at the time of the PET/CT scan in order to provide a timely and complete report.

Contact Name: \_\_\_\_\_

Previous CT/MRI/CXR films and reports available at: \_\_\_\_\_

**PLEASE FAX INSURANCE CARD (FRONT & BACK) ALONG WITH ALL PERTINENT CLINICAL INFORMATION TO 817-321-0399**

**PLEASE FAX COMPLETED FORM TO 817.321.0399.**

**(THIS FORM NEEDS TO BE FAXED 2-3 DAYS IN ADVANCE OF SCHEDULED APPOINTMENT) TO SCHEDULE PLEASE CALL 817.321.0470.**

**DUE TO THE COST OF THE INJECTION MEDICATION, THE APPOINTMENT MUST BE CONFIRMED WITH OUR OFFICE BY 4:00 P.M. THE BUSINESS DAY PRIOR TO APPOINTMENT, OR THE PROCEDURE WILL BE CANCELED.**

This facsimile may contain PRIVILEGED, CONFIDENTIAL AND/OR OTHERWISE PROTECTED INFORMATION intended only for the use of the addressee. Unauthorized distribution or use of the facsimile or its contents is strictly prohibited. If you are not the addressee, the person responsible for delivering this message to the addressee, or if you have received this facsimile in error, please immediately notify us by telephone at the number above and destroy this information. Thank You.