

PATIENT NAME:	PATIENTS INSURANCE:	PRE-CERTIFICATION NUMBER:
MEDICAL RECORD #	WORK PHONE #:	____ FEMALE (Age 12-50) PREGNANT ____ YES
BIRTHDATE:	HOME PHONE #:	____ MALE ____ NO
AGE:		
ADDRESS:		
_____ INPATIENT _____ UNIT _____ RM# _____ EXT.		
_____ DIABETIC _____ BLOOD SUGAR LEVEL _____ WEIGHT _____ HEIGHT		

DURING PET SCAN PATIENT WILL NEED:
 ____ FOLEY CATHETER ____ IV SEDATION ____ PO VALLIUM

CONTACT PERSON/RESIDENT:	PHONE #:	DATE OF SCAN:	TIME:
REFERRING/ATTENDING DR:	FAX REPORT TO:	MAIL REPORT TO:	E-MAIL REPORT TO:

PROCEDURE TYPE:

____ PET BRAIN METABOLISM	____ PET HEART METABOLISM	____ PET SCAN METABOLISM
____ PET BRAIN PERFUSION	____ PET HEART PERFUSION	____ PET SCAN WHOLEBODY
____ PET BRAIN INITIAL TX	____ PET SCAN TORSO INITIAL TX	____ PET SCAN WB INITIAL TX
____ PET BRAIN SUBSEQUENT	____ PET SCAN TORSO SUBSEQUENT	____ PET SCAN WB SUBSEQUENT

DIAGNOSIS CODE: RATIONALE FOR PET SCAN:

IMAGING STUDIES	DATE	BODY SITE	FILM LOCATION/PHONE NUMBER

PRIMARY DIAGNOSIS:	DATE OF DIAGNOSIS:	TUMOR MARKER MONITORING:
		TUMOR MARKER DATE:
KNOWN METS:	DATE OF DIAGNOSIS:	_____ _____
		_____ _____
		_____ _____

PROCEDURE/TYPE:	DATE:	LOCATION:	AMOUNTS:
SURGERY / _____	_____	_____	_____
BIOPSIES _____	_____	_____	_____
RADIATION _____	_____	_____	_____
THERAPY _____	_____	_____	_____
CHEMO _____	_____	_____	_____
THERAPY _____	_____	_____	_____
IMMUNO _____	_____	_____	_____
THERAPY _____	_____	_____	_____

DATE SCHEDULED: _____ SCHEDULED BY: _____