

PET/CT REQUEST FORM

MRN: Patient Name):
	(Patient Label)

Date of Request:					
Height in		jht		☐ kg	
lodine or other Allergies:					None
Primary Diagnosis:				ICD10:	
Pertinent clinical history:					
PURPOSE OF PET/CT					
Please specify one: Initial	Treatment Strate	egy 🗌 S	ubsequent Tr	eatment St	rategy
Please select the appropriate p	procedure:				
□ PET/CT (base of skull to up□ Neck □ Chest □ About					ies
*For Diagnostic CT, please prov (Note: Serum Creatinine level					
roquirod)					
required)					
☐ PET/CT Brain only		Diama atta O	T	4 5	
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☐ PET/CT Brain only ☐ PET/CT (base of skull to up	od 🗌 Pelvis 🗀	Lower Extren	nities 🗌 Uppe	er Extremit	
☐ PET/CT Brain only ☐ PET/CT (base of skull to up ☐ Neck ☐ Chest ☐ Ab	od Pelvis cause of medical	Lower Extren	nities Uppe n to IV contrast	er Extremit	ties
☐ PET/CT Brain only ☐ PET/CT (base of skull to up ☐ Neck ☐ Chest ☐ Ab (CT without IV contrast becomes perfectly becomes of skull to up)	od ☐ Pelvis ☐ cause of medical o	Lower Extren contraindication nly for localiza	nities □ Uppe n to IV contrast ation & attenu	er Extremit) ation corre	ection*
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PET/CT Brain only PET/CT (base of skull to up Neck Chest Ab (CT without IV contrast becomes PET/CT (base of skull to up) Referring MD: Asst: Address: Patient Insurance:	pd Pelvis cause of medical causes of medica	Lower Extrencontraindication nly for localization ID#/) Auth NOTES AND Prescription: Adult Patient Pediatric Pat MD Signatur Pager/ID #: Print Name:	nities Upper to IV contrast ation & attenual UPIN Fax #:(er Extremit) ation corre	ection* 22 mCi p to 15 mCi

Comments:

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