



APPOINTMENT SCHEDULED FOR: _____ / _____
Date Time

PATIENT INFORMATION

First Name: _____ Last Name: _____

DOB: _____ Primary Phone: _____

Male Female Patient Height: _____ Patient Weight: _____ (Needed to order Radiopharmaceutical)

Patient Mobility: Ambulatory Wheelchair Stretcher Other _____

Insurance Plan: _____ Plan #: _____ Pre-Auth #: _____

Worker's Compensation: Yes No If yes, Employer Name: _____ Employer Phone #: _____

PHYSICIAN INFORMATION

Ordering Provider: _____ cc: _____

Office Phone: _____ Cell Phone: _____ Pager #: _____

Signs/Symptoms /Reasons for Exam (REQUIRED): _____

ICD 10 Codes (REQUIRED): _____

Primary Care Physician Name: _____

Provider Signature: ** _____ Date: _____

****MUST BE ORIGINAL SIGNATURE ; STAMPED SIGNATURES NOT ACCEPTED**

PATIENT HEALTH HISTORY QUESTIONS :

- ALLERGIES NO YES IF YES, SPECIFY _____
- PREGNANCY / BREAST FEEDING NO YES
- PRECAUTIONS NO YES IF YES, TYPE : _____
- PRIOR CT or PET STUDIES NO YES RIH/TMH/RIMI/SHIELDS/NEWPORT OUTSIDE : _____
- DIABETIC NO YES INSULIN
- XRT / SURGERY NO YES TYPE : _____

EXAM REQUESTED : CHECK ONLY ONE EXAM

- | | | | |
|---|--|---|---|
| BRAIN
<input type="checkbox"/> Seizure
<input type="checkbox"/> Dementia | MELANOMA
<input type="checkbox"/> Staging, Initial
<input type="checkbox"/> Restaging | BREAST CANCER
<input type="checkbox"/> Staging for distant metastatic disease
<input type="checkbox"/> Restaging
<input type="checkbox"/> Therapeutic Response Monitoring | OVARIAN CANCER
<input type="checkbox"/> Staging
<input type="checkbox"/> Restaging |
| CARDIAC
<input type="checkbox"/> Myocardial viability
<input type="checkbox"/> Cardiac Sarcoid
<input type="checkbox"/> Myocardial Perfusion (PET/CT) | HEAD & NECK CANCER
<input type="checkbox"/> Staging, Initial
<input type="checkbox"/> Restaging | LUNG CANCER (non-small cell)
<input type="checkbox"/> NSCLC Initial Staging
<input type="checkbox"/> NSCLC Restaging | CERVICAL CANCER
<input type="checkbox"/> Staging
<input type="checkbox"/> Restaging |
| ESOPHAGEAL CANCER
<input type="checkbox"/> Staging, Initial
<input type="checkbox"/> Restaging | LYMPHOMA
<input type="checkbox"/> Staging, Initial
<input type="checkbox"/> Restaging | COLORECTAL CANCER
<input type="checkbox"/> Staging, Initial
<input type="checkbox"/> Restaging | PROSTATE PSMA IMAGING
<input type="checkbox"/> Staging
<input type="checkbox"/> Restaging |
| THYROID CANCER
<input type="checkbox"/> Staging
<input type="checkbox"/> Restaging | MYELOMA
<input type="checkbox"/> Staging, initial
<input type="checkbox"/> Restaging | <input type="checkbox"/> SOLITARY PULMONARY NODULE
* nodule must be greater than or equal to 7mm | NEURO ENDOCRINE DOTATATE IMAGING
<input type="checkbox"/> Staging
<input type="checkbox"/> Restaging |
- OTHER** _____

Allergies _____