

Date scheduled: _____

By: _____

Date requested: _____

Preferred time: _____

WHOLE BODY P.E.T. SCAN
Registration / Scheduling Intake

Pt Name _____ D.O.B. _____ Age: _____

Address _____ Ht: _____ Wt: _____

City: _____ State: _____ Zip: _____

Phone: Home _____ Work: _____ Other _____

Social Security Number: _____

Insurance: _____ Authorization number: _____

Referring M.D. _____ New referral: (

Phone: _____ Fax: _____

Clinical Information

Primary Diagnosis _____ ICD9 code _____

Clinical indication / question _____ Meets appropriate criteria: (

Special Instructions _____
(i.e. patient requires interpreter, blind, deaf, bladder catheter, requires sedation)

Please circle all that apply:

- | | | | | | |
|--------------------|-------------|-------------------|---------------------|-----------|-----------------|
| Incontinence | Colostomy | Ileostomy | Indwelling catheter | Infection | |
| Drains/Open wounds | Pacemaker | Artificial joints | Implants | Arthritis | Recent injuries |
| Claustrophobia | Laryngotomy | Tracheostomy | Gastostomy | | |

Diabetes – If so, how controlled? Diet Oral Meds Insulin Allergies - If so, to: _____

Medications,
dosage: _____

Notes:

Support documentation: (Please fax a copy of all reports and have patient bring their films to their appointment.)

H&P or chart notes: Requested: _____ Date Received: _____

Previous Studies:	Date	Location performed	Date requested	Received
Nuc Med	_____	_____	_____	_____
C.T.	_____	_____	_____	_____
M.R.I	_____	_____	_____	_____
Op & Path	_____	_____	_____	_____

Copies of PET results to: _____

Notes about scheduling a patient:

Please fax a signed physicians prescription, copies of this form and all reports to Clinical P.E.T. of West County (314.567.4346).

Please have patient bring copies of all previous scans- WE WILL BE UNABLE TO READ THE STUDY WITHOUT THESE FILMS.

Please tell the patient to be NPO for at least 4 hours prior to exam time.

Please ask the patient to refrain from any strenuous activity for at least 24 hours prior to exam time.

Please ask the patient to bring a list of current medications and to refrain from taking them until after the scan if possible (call for special diabetes instructions).

Please ask the patient to wear comfortable clothes and no underwire bras.

If this form has not been completed and faxed along with the reports, we will be unable to schedule the patient. If the patient does not arrive with the films, we will be unable to release a report.

If you or your patient have any questions, please do not hesitate to call Terri or Tracy at Clinical P.E.T. of West County (314.567.4343).

Office Use Only

Dose: _____ mCi FDG Time: _____ Injection Site: _____ Injected By: _____