

To: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Re: Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SS # : \_\_\_\_\_

Type of Films Requested: CXR, CT, MRI, NUCLEAR MEDICINE, PET SCAN

Type of Reports Requested: CXR, CT, MRI, PET SCAN, LAB, PATHOLOGY,  
AND SURGICAL

The above named patient has authorized and requested that all previous scans performed at your institution be released to Clinical P.E.T. of West County. The films will be picked up by the patient or a representative of Clinical P.E.T. of West County.

This request is made with the understanding that these films will be returned to your institution or the patient upon completion of review.

If no prior scans on the patient can be located, please notify us as soon as possible at (314) 567 - 4343.

Thank you in advance for your prompt assistance.

Patient's Signature \_\_\_\_\_

Witness' Signature \_\_\_\_\_

Films Received: \_\_\_\_\_

Films Returned: \_\_\_\_\_