Valley Radiology CONSULTANTS

PARKWAY ON ELM
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PET/CT SCHEDULING FORM

PATIENT INFORMATION	**REFERRING INFORMATION**
Name:	Referring Physician:
Date of Birth: Age:	Date:
Address:	Phone: Fax:
Phone: Home Cell:	Insurance Name:
Height/Weight: [ ] Male [ ] Female	Authorization #:

PET/CT EXAM REQUESTED
[ ] 78815 – PET/CT (Skull base to thighs)
[ ] 78816 – PET/CT (scalp to toes for sarcoma or melanoma)
[ ] 78608 – PET/CT (Brain for dementia/seizure)
[ ] 78816 – PET/CT (Bone scan for Prostate CA to evaluate bone metastasis)

Primary Diagnosis:	ICD code:

Reason for Study:
[ ] Initial treatment strategy (diagnosis/initial staging) [ ] Subsequent treatment strategy (restaging/monitoring/recurrence)

Recent surgery/biopsy: Specific site, date and where done:	Recent relevant imaging: Location:_____________________ [ ] CT [ ] MRI [ ] NM [ ] PET:______________________
Chemotherapy: Type and date of last treatment	Radiotherapy: Type and date of last treatment
Patient diabetic: [ ] Yes [ ] No	Diabetic Medications: [ ] Oral (Type:____________) [ ] Insulin (Type: ____________)

CHECK LIST FOR PHYSICIAN'S OFFICE
[ ] Completed VRC scheduling form
[ ] Copies of (non-VRC) CT, MRI, and Nuc Med reports & images, as well as relevant consult notes and pathology reports
[ ] Copies of all insurance cards and picture ID
[ ] Preparation documentation provided to the patient

IMPORTANT
Call the PET scheduler for preparation instructions.
At least 48 hours notice is required to cancel or reschedule the exam.

Glucose Level: ________________________ Assay Dose: ___________________________ Time: ____________

Tech: _______________________________ Residual Dose: _________________________ Time: ____________

DOSE TICKET	DOSE TICKET