PREFERRED PET IMAGING OF KANSAS

825 N. Emporia • Wichita, KS 67214 Phone (316) 269-1PET(1738) • Fax (316) 269-1759

PET/CT SCAN ORDER FORM

Referring Physician: _____ Scheduler's Name: _____
Phone #: _____ Fax #: _____

PATIENT INFORMATION

Name _____ S.S. # _____
Address _____ Date of Birth _____
City, State _____ Home Phone _____
Other Phone _____

INSURANCE

Primary _____ Phone # _____
Member ID _____ Authorization # _____

Secondary _____ Phone # _____
Member ID _____ Authorization # _____

MEDICAL HISTORY

Reason for Exam _____ Pt. Height _____ Pt. Weight _____
Previous History:
(cancer, surgeries, etc.) _____

Is Your Patient…?

Claustrophobic? □ Yes □ No
On Oxygen? □ Yes □ No
Diabetic? □ Yes □ No
Receiving Skilled Nursing Service? □ Yes □ No
Currently on Radiation Therapy? □ Yes □ No
Currently on Chemo? □ Yes □ No

Has your patient had any of the following in the past year? Please list facility.

□ C.T. _____ □ M.R.I. _____ □ PET _____ □ OTHER _____

Please have patient bring copies of the above tests with them to their appointment.

PHYSICIAN ORDER

PET/CT Scan (mark one)
□ Skull Base to Mid-thigh (**Routine**)
□ Whole Body (e.g. melanoma)
□ Cardiac
□ Brain

Purpose (mark one)
□ Initial Treatment Strategy
□ Subsequent Treatment Strategy

Written Diagnosis and Code: _____ **Physician Signature:** _____

Fax completed order with notes and reports to (316) 269-1759.
Thank you.