



PET-CT Bone Requisition Form

Date: _____ Repeat Patient: Y / N

Patient's last name: _____ First name: _____ Date of birth: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Gender: M / F Height: _____ Weight: _____

Referring Clinician: _____

Diagnosis for PET-CT fusion scan and area of concern (ICD-9 code required):

Prior scans:

Prior surgery:

PET-CT Bone Scan

Whole body PET-CT bone

Limited PET-CT bone

Area of concern: _____

* If you require any additional imaging i.e. CT, MRI, ultrasound, please fill out a separate PIC order form. As a reminder, every PET-CT done at PIC includes a non-contrast, low dose CT scan to fuse with the PET images.

Clinician signature: _____