



PET-CT 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: _____ Insulin dependent diabetic? Y / N

Referring Clinician: _____

Diagnosis for PET/CT fusion scan (ICD-9 code required):

Treatment

Radiation: _____

Chemotherapy: _____

Surgery: _____

PET-CT Fusion Scan

Whole body PET-CT PET-CT Bone Scan Brain PET-CT Cardiac PET-CT

Diagnosis Initial Staging Tumor monitoring during tx Restaging at completion of tx

Suspected recurrence

* If you require any additional imaging ie. 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: _____