



1929 MOORES LANE • TEXARKANA, TX 75503  
TAX I.D. 72-1513569  
PH: 903-794-1194 • FAX: 903-794-1996

## PET/CT PRESCRIPTION

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

Thank you for referring your patient for a PET/CT scan. In order to expedite the approval and scheduling process, please provide the following information about your patient.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ SSN: \_\_\_\_\_

Gender: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. Diabetic: Yes \_\_\_\_\_ No \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Office Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Reason for Scan: \_\_\_\_\_

Diagnosis Code: \_\_\_\_\_

Primary Insurance is: \_\_\_\_\_

Patient's return office visit date: \_\_\_\_\_

### **Please fax the following items to the PET/CT Institute at (903) 794-1996.**

- ★ Completed Prescription form
- ★ Recent history and physical
- ★ All recent imaging study reports, CT, MRI, Ultrasound & Nuclear Medicine
- ★ Lab values for tumor markers (CEA, CA-125 etc.)
- ★ Photo copy of front and back of insurance card(s)

### **Procedure Requested for above patient:**

- [ ] **Whole Body Tumor Localization / FDG**
  - ★ Normal parameters for the scan are canthomeatal line to mid-thigh
- [ ] **Brain / FDG**
- [ ] **F-18 Axumin Scan**
- [ ] **F-18 PSMA Pylarify Scan**
- [ ] **Whole Body for Melanoma / Myeloma**

Physician Signature: \_\_\_\_\_