



PET/CT Imaging Request Form

Please fax your request and a copy of your patient's insurance card to:
559-432-7020

Patient Information

Patient Name: _____ Date of Birth: _____

Phone Number: Home _____ Work _____ Cell _____

Insurance Carrier: Primary _____

Secondary _____

We will be happy to help obtain insurance authorization for you whenever possible.

History of: Diabetes? Yes No Renal Failure/Insufficiency? Yes No

Indication: _____ ICD-9: _____

Please select one of the three options below:

PET **Note:** All VMI PET studies are performed on a PET/CT scanner using low-dose CT for attenuation correction and anatomic localization.

Whole Body Cardiac Brain

PET with Diagnostic CT (16-Slice) Please Complete Steps 1-3

PET and Diagnostic CT can be performed simultaneously. Select this option to schedule this time-saving exam for your patient.

1 PET Whole Body Cardiac Brain **2** CT Head Sinus Neck Chest Spine _____ Pelvis Extremity _____ Abdomen Other _____ **3** With Contrast Without Contrast If Indicated (Radiologist's Review)

Diagnostic CT (16-Slice) Please Complete Steps 1-2

1 Head Neck Abdomen Pelvis Chest Sinus Spine _____ Extremity _____ Other _____ **2** With Contrast Without Contrast If Indicated (Radiologist's Review)

Referring Physician's Name: _____ Phone Number: _____

Referring Physician's Signature: _____

Additional Copies of Report To: _____