



Study Request Form

3503 N. Campbell Ave; Suite 155 Tucson, AZ 85719 Ph. (520) 321-4057 Fax (520)321-4061

Name: _____ DOB: _____ Home Phone: _____

Address: _____ Work Phone: _____

CT <input type="checkbox"/> Contrast <input type="checkbox"/> Non-contrast <input type="checkbox"/> Head/Brain <input type="checkbox"/> Sinuses/Maxillofacial <input type="checkbox"/> Temporal Bone/IAC/CPA <input type="checkbox"/> Sella/Pituitary <input type="checkbox"/> Orbits <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Spine <input type="checkbox"/> C <input type="checkbox"/> T <input type="checkbox"/> L <input type="checkbox"/> Upper Extremity R or L <input type="checkbox"/> Lower Extremity R or L <input type="checkbox"/> Other	If Contrast Study BUN _____ Creatinine _____ Lab Date: _____ (within 45 days) <input type="checkbox"/> Asthma <input type="checkbox"/> Contrast Allergy <input type="checkbox"/> Renal Insufficiency	PET/CT <input type="checkbox"/> Initial Staging <input type="checkbox"/> Restaging <input type="checkbox"/> Establish Dx <input type="checkbox"/> Skull Base to Thigh (lung, breast, colon, etc.) <input type="checkbox"/> Whole body (melanoma, renal cell, etc.) <input type="checkbox"/> Setup for RTP <input type="checkbox"/> Myocardial Viability <input type="checkbox"/> Brain <input type="checkbox"/> EEG
<input type="checkbox"/> Diabetic Ht. _____ Wt. _____ (450 Lb. wt. maximum)		
Ref. Phys: _____ cc: _____ Phone: _____ Fax: _____ Contact: _____ Dx: _____ ICD-9: _____		

PREVIOUS STUDIES?

- PET, CT and/or MR (fax report) _____
- Other (fax report) _____
- Pathology (fax report which supports clinical indication) _____
- Surgeries /Biopsies (fax report) _____
- Radiation Therapy and/or Chemotherapy (when was the last treatment or when will it begin?) _____
- Blood Cell Stimulation Injection (e.g. Neulasta/Neupogen) If yes, when? _____

Clinical Trial Bill to: Accommodation# _____ Insurance
 (Provide Bi-directional Measurements and Comparisons in Report)

INSURANCE INFORMATION

Primary _____ Secondary _____
 ID# _____ ID# _____
 Phone _____ Phone _____

Requested Appointment Date: _____ Appointment Time: _____
 (Not Valid Without) **PHYSICIANS SIGNATURE:** _____

Thank you for referring your patient to Southwest PET/CT Institute