PET/CT ORDER FORM

CHEYENNE RADIOLOGY

Date: _____/_____/_____ Appointment Date & Time: _____/_____/_____ _____:_____ ☐ AM ☐ PM

Patient Name: _____

Date of Birth: _____/_____/_____ Weight: _____ Diabetic: ☐ YES ☐ NO

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Alternate Phone: _____

Insurance: _____ Insurance Phone: _____

☐ Differentiate benign from malignant lesion:
- ☐ Pulmonary Nodule
- ☐ Other (Specify): _____

☐ Evaluation of abnormality on another study:
- ☐ CT ☐ MRI
- ☐ Other (Specify): _____

☐ Staging of known/suspected cancer:
- ☐ Diagnosis ☐ Initial Staging ☐ Restaging

Type of Cancer: _____ Diagnosis Proven: _____

History/Reason for Exam: _____

_____

_____

_____

_____

☐ 78816 Whole Body

☐ 78815 Vertex to mid thigh

☐ 78814 Limited Area (chest, head, neck)

☐ 78608 Brain
Metabolic Evaluation

Thank you for choosing Cheyenne Radiology. If you have any questions or concerns, feel free to contact our office at 307-634-7711.

Physican Signature:_____ Date: _____/_____/_____

Printed: _____