PET/CT ORDER FORM

CHEYENNE RADIOLOGY

Date: _____/_____/_____

Patient Name: _____

Date of Birth: _____/_____/_____ Weight: _____

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
- ☐ 78816 Sodium Fluoride NaF
- ☐ 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.

Physician Signature: _____ Date: _____/_____/_____

Printed: _____