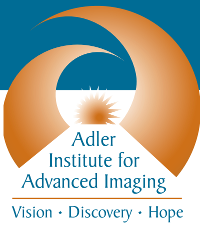

PATIENT SCHEDULING FORM

261 Old York Road, Suite 106 Jenkintown, PA 19046 215-935-0030

☐ **PET/CT SCAN:** ☐ Whole Body ☐ Brain ☐ Cardiac Viability ☐ Other ____________

select one: ☐ Diagnosis ☐ Staging ☐ Restaging ☐ Response to Therapy

☐ **CT SCAN:** ☐ Chest ☐ Abdomen ☐ Pelvis ☐ Other ____________

select one: ☐ W/ Contrast ☐ W/O Contrast ☐ W/ & W/O Contrast

☐ **CT Angiography:** location ____________

ICD-9 Code: ____________ **Reason for Scan (Clinical History):** ____________

Type of Primary Cancer: ____________ All other Cancers ____________

☐ RADIATION THERAPY (suggest 6-8 week wait after completion) Anatomic location: ____________ Date completed ____________

☐ CHEMOTHERAPY (suggest 4-6 week wait after completion) ☐ Currently receiving ☐ Date Completed ____/____/________

PATIENT NAME: ____________

Sex: M / F DOB:____/____/________ S.S#:____________

Day Phone: (________)____________ Evening: (________)____________

Address: ____________

____

Emergency Contact: ____________Phone: (________)____________

Primary Insurance: ____________

Subscriber Name: ____________

Social Security: ____________ Subscriber DOB:____/____/________

Policy #: ____________ Group#: ____________

Secondary Insurance: ____________

Subscriber Name: ____________

Social Security: ____________ *Subscriber DOB:* ____/____/________

Policy #: ____________ *Group#:* ____________

Referring Physician Information

Physician: ____________

Specialty: ____________

Address: ____________

____

Phone: (________)____________

FAX: (________)____________

Office Contact: ____________

cc Physician: ____________

FAX: (________)____________

cc Physician: ____________

FAX: (________)____________

cc Physician: ____________

FAX: (________)____________

☐ Call Stat ☐ Fax ☐ Email

Pre Cert/Auth #:____________

Patient History:

a.) **Height:** ________ **Weight:** ________ b.) **Is patient pregnant?** ☐ Yes ☐ No c.) **Breast Feeding?:** ☐ Yes ☐ No

d.) **Allergies?:** ☐ None ☐ Iodine ☐ Shellfish ☐ Other ____________ e.) **Abscess/Infection?** ☐ Yes ☐ No

f.) **Asthma?** ☐ Yes ☐ No g.) **Diabetes?** ☐ Yes ☐ No *If yes, please select one:* ☐ Oral ☐ Insulin ☐ Glucophage

h.) ***<u>Necessary for all patients over 65 only:</u>*** Creatinine: ________ BUN: ________

i.) **Has patient had surgery/biopsy?** ☐ Yes ☐ No Date: ____/____/________ Type:____________

j.) **Recent CEA Level:** ____________ **CA125 level:** ____________

k.) **Has patient had any Fluoro studies (Upper GI or BS) in the last 2 weeks?** ☐ Yes ☐ No Date: ____/____/________

l.) **Previous CT or MRI?** ☐ Yes ☐ No Date: ____/____/________ Where: ____________

m.) **Previous PET Scan?** ☐ Yes ☐ No Date: ____/____/________ Where: ____________