



PATIENT REFERRAL FOR PET-CT SCANS

To give your patient the best medical care possible, we need the information listed below. Please fax the completed form to **732-390-5038** or ask your patient to bring it with them to their appointment.

Patient Name _____

Date of Birth _____ **Height** _____ **Weight** _____

Home Phone _____ **Work Phone** _____

Referring MD _____

MD's Phone _____ **MD's Fax** _____

Exam Requested

- Brain Metabolism
- Melanoma Study
- Tumor Whole Body Metabolism
- Other _____

Primary Diagnosis _____

ICD-9 Code _____ Diagnostic Study Staging Restaging

Treatment	Date Started	Date Completed
Chemo	_____	_____
Radiation	_____	_____

Previous Studies	Date	Location
CT	_____	_____
MRI	_____	_____
PET	_____	_____

Is the patient diabetic? Yes No Oral Meds Insulin Other _____

Precertification Number _____

Please include a copy of the front and back of the patient's current insurance card.