PET-CT

UNIVERSITY RADIOLOGY GROUP PC

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.

800-758-5545

University Radiology PET-CT Center ▪ 483 Cranbury Rd. ▪ East Brunswick ▪ Fax 732-390-5038

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