



**PET/CT**

Patient Name:		DOB:
Home Phone Number:	Work Phone:	Alternate Number:
Referring Physician:		Office Phone:
Physician's Address:		Fax #:
Clinical History:		
Is the patient diabetic?    Yes    No	If yes, list medications:	
BUN: _____    CR: _____		
Is the patient pregnant?    Yes    No	Is the patient claustrophobic?    Yes    No	
Physician Signature:		Date:

**PET/CT**

Please indicate type of Scan:

PET/CT Whole Body

PET/CT Brain

Hours of Operation:

Monday – Friday 8am – 4pm, Sunday 9am-4pm

Please call 212.977.4100 to schedule an appointment.

Appointment Date / Time: \_\_\_\_\_

Pre-Auth#: \_\_\_\_\_

Please have your insurance card available.

**Please Note: Co-payments are collected at time of visit.**