



PET/CT

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|---|-------------|---|
| 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 BUN: _____ CR: _____ | | If yes, list medications: |
| 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

F-18 Fluoride PET Bone Imaging

Hours of Operation:

Monday, Wednesday and Friday 8am – 4pm

Tuesday and Thursday 8am – 8pm

Saturday 8am – 2pm

Please call 212.473.2300 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.