



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 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

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.