REQUEST FOR SERVICE FORM

Date Requested: ______________________

PATIENT INFORMATION

Name:	DOB:	E-mail:	
Home/Evening Phone:	Work/Cell Phone:		
Date Scan needed:	Height:	Weight:	Male ☐ Female ☐

CLINICAL INFORMATION

Diagnosis/Chief Complaint: | ICD-9 Code:

History and staging information: ☐ Initial Diagnosis ☐ Staging ☐ Re-Staging ☐ Response to Treatment

Diabetic: yes ☐ no ☐	History of contrast reaction: yes ☐ no ☐	Pregnant or breast-feeding: yes ☐ no ☐
Ambulatory: yes ☐ no ☐	Skilled Nursing facility: yes ☐ no ☐	Anxiety or claustrophobia: yes ☐ no ☐

EXAMINATION INFORMATION

PET/CT Exam: ☐ Skull base to mid-thigh ☐ Whole body/Melanoma ☐ Brain Imaging ☐ PET Bone

Diagnostic CT Exam:

Without and with IV contrast:	☐ Neck	☐ Chest	☐ Abdomen	☐ Pelvis	☐ Head	☐ Other
Without IV contrast :	☐ Neck	☐ Chest	☐ Abdomen	☐ Pelvis	☐ Head	☐ Other
With IV contrast:	☐ Neck	☐ Chest	☐ Abdomen	☐ Pelvis	☐ Head	☐ Other

Patient has: ☐ Difficult venous access history ☐ Port ☐ Power port

For contrast exam, please attach BUN/Creatinine lab work < 30 days old.

INSURANCE INFORMATION

Private ☐ Medicare ☐ Self-Pay ☐ Other ☐ | Authorization needed: yes ☐ no ☐

Insurance Carrier:	ID subscriber #:	Auth #:
Customer Service Phone:	NOPR: yes ☐ no ☐	

REFERRING PHYSICIAN INFORMATION

Name:	NPI:	U-PIN:	
Office Number:	Fax:	Submitted by:	
Street Address:	City:	State:	Zip Code:

MD Signature X:

Report delivery preference: Email ☐ Fax ☐ Mail CD ☐ Will access on Web/PACS ☐

CC to: Email ☐ Fax ☐ Mail CD ☐

SCHEDULING INFORMATION (FOR MOITC USE ONLY)

Initial call to schedule patient (date, time, initials):

Date of scheduled exam:	Date of follow-up all (date, time, initials):
If cancelled, reason for cancellation:	Date cancelled (date, time, initials):