

**North Fork Radiology
P.E.T. Scan**

Patient Name _____ Day Time Phone # _____

Date of Birth _____ Age _____ Weight _____

Referring Physician _____ Phone # _____

Appointment Date _____ Appointment Time _____

PET Scan Type _____ Reason for Exam _____

Please Check Appropriate Clinical Indication

Oncology/Cancer

____ Benign VS Malignant Lesion ____ Initial Staging ____ Restaging Follow Up

Cardiology

____ Tumor ____ Tissue Viability

Neurology

____ Dementia ____ Epilepsy

Primary Insurance _____ Secondary Insurance _____

Is a precertification needed?

If Yes Precertification # _____

Background/History

History of Cancer? If Yes, what type, have you received Radiation or
Chemotherapy treatments and when were you diagnosed?

Any Previous Surgeries? Please Describe, what type and why.

Any Allergies? _____

History of Diabetes? Y or N If Yes type of drug maintenance _____

Any previous PET scan studies performed? When, and where were they
performed?
