

# POSITION EMISSION TOMOGRAPHY / COMPUTERIZED TOMOGRAPHY

**Advanced Molecular Imaging**  
DENT Tower – PET/CT Suite  
3980 Sheridan Drive  
Amherst, NY 14226



**Phone: (716) 250 - 4PET (4738)**  
**Fax: (716) 829 - 2348**

**DENT PET Center**  
Millard Fillmore Hospital  
3 Gates Circle  
Buffalo, NY 14209

## REQUEST FOR STUDY

- PET / CT Study**    With Contrast     Without Contrast     Available at DENT Tower only  
 **Diagnostic CT**    With Contrast     Without Contrast     Available at DENT Tower only  
 **PET Study**    Available at Gates Circle & DENT Tower

## GENERAL PATIENT INFORMATION

Date of Request \_\_\_ / \_\_\_ / \_\_\_    Gender: Male  Female   
Patient Name \_\_\_\_\_    Diabetic? Yes  No   
Patient SS# \_\_\_\_\_    Claustrophobic? Yes  No   
Address: \_\_\_\_\_    Allergies? No  Yes  \_\_\_\_\_

## PATIENT INSURANCE INFORMATION

DOB \_\_\_ / \_\_\_ / \_\_\_    Age \_\_\_\_\_    Insurance Authorization #: \_\_\_\_\_  
Height \_\_\_\_\_    Weight \_\_\_\_\_    Primary Plan \_\_\_\_\_    Policy ID# \_\_\_\_\_  
Daytime Phone # \_\_\_\_\_    Work# \_\_\_\_\_    Secondary \_\_\_\_\_    Policy ID# \_\_\_\_\_

## PATIENT HISTORY

Has the Patient had a previous PET scan? Yes  No     If yes, date of scan \_\_\_ / \_\_\_ / \_\_\_  
Location of previous scan \_\_\_\_\_  
Reason(s) for Ordering PET study: Initial/Diagnostic  Staging  Follow-Up  Clarify Equivocal Findings   
Please provide copy of results and dates for each of the following diagnostic tests that have been ordered:  
CT  \_\_\_ / \_\_\_ / \_\_\_    MRI  \_\_\_ / \_\_\_ / \_\_\_    CRX  \_\_\_ / \_\_\_ / \_\_\_    Endoscopy  \_\_\_ / \_\_\_ / \_\_\_    Biopsy  \_\_\_ / \_\_\_ / \_\_\_

### Neurology Request:

Dementia /Alzheimer's Disease     Epilepsy     Parkinson's Disease   
Other:  \_\_\_\_\_

### Oncology Request:

Type of Primary Cancer \_\_\_\_\_    Date of Diagnosis \_\_\_ / \_\_\_ / \_\_\_  
Histology \_\_\_\_\_    Recurrent \_\_\_\_\_    Date of Recurrent Diagnosis \_\_\_ / \_\_\_ / \_\_\_  
Stage of Disease \_\_\_\_\_  
Date of Prior Therapy/Surgery \_\_\_ / \_\_\_ / \_\_\_    Chemo \_\_\_ / \_\_\_ / \_\_\_    Radiation \_\_\_ / \_\_\_ / \_\_\_

## ORDERING PHYSICIAN CONTACT INFORMATION

Ordering Physician Name \_\_\_\_\_    Insurance Provider #: \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    Fax (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## PET STUDY INFORMATION

**To be completed by the PET physician**    INTERNAL CODE \_\_\_\_\_  
 Indicated    Protocol \_\_\_\_\_    Area to be scanned \_\_\_\_\_  
 Not Indicated    \_\_\_\_\_    Priority \_\_\_\_\_  
Signature of PET Physician \_\_\_\_\_    Date \_\_\_ / \_\_\_ / \_\_\_