# POSITION EMISSION TOMOGRAPHY / COMPUTERIZED TOMOGRAPHY

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

DENT IMAGING CENTERS

**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 ____/____/____

Patient Name _____

Patient SS# _____

Address: _____

_____

DOB ____/____/____ Age _____

Height _____ Weight _____

Daytime Phone # _____ Work# _____

Gender: Male ☐ Female ☐

Diabetic? Yes ☐ No ☐

Claustrophobic? Yes ☐ No ☐

Allergies? No ☐ Yes ☐ _____

### PATIENT INSURANCE INFORMATION

Insurance Authorization #: _____

Primary Plan _____ Policy ID# _____

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 ____/____/____