Brookings HEALTH SYSTEM

PET/CT: APPT DATE_____ TIME_____
PHYSICIAN RETURN: APPT DATE_____ TIME_____
Time/Date form completed:_____/_____ Signature of person completing form:_____

PATIENT INFORMATION

Patient name:_____ DOB:_____ Social Sec. #:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone number: (____) _____ Work number: (_____) _____ Cell Phone: (_____) _____

Referring physician:_____ Phone #: (_____) _____

Primary diagnosis/reason for study:_____ICD10 code:_____

Height:_____Weight:_____

Is patient is diabetic? **YES / NO** If yes, how is diabetes controlled? ☐ Diet ☐ Insulin ☐ Oral Meds
Is patient claustrophobic? **YES / No If YES, please have the physician prescribe medication for the exam.**
If patient has oral medication, the technologist will advise the patient on when to tale the medication.
(REMINDER: the patient will need a ride home after the exam if medication is taken!)
Is patient pregnant or nursing? **YES / NO**
Allergies:_____

Medications:_____

DATE OF LAST:

Chemotherapy:_____ Radiation Therapy:_____ Surgery (include location)_____
PET Scan (please list where study was performed):_____
MRI (please list where study was performed): _____
CT (please list where study was performed): _____

INSURANCE INFORMATION

Primary insurance company:_____ Name of insured: _____
Policy number:_____ Group number:_____- _____
Secondary Insurance company:_____ Name of insured:_____
Policy number:_____Group number:_____-_____

P.E.T ORDER

☐ Oncology ☐ Brain ☐ Cardiac

Diagnosis is required to insure appropriate protocol:

☐ Esophageal ☐ Lymphoma ☐ Head/neck
☐ Breast ☐ Brain ☐ Melanoma
☐ Colorectal ☐ Lung ☐ Single pulmonary nodule
☐ **Other:**_____

Indicate purpose of study:

☐ Diagnosis
☐ Initial treatment strategy
☐ Subsequent treatment strategy

Please fax or send the following information to our office before the date of the scheduled exam. In the interest of quality patient care a patient report will be held until all the information is received.

☐ **Recent labs** (CEA Levels, CA 19-9, CA 125) ☐ **Surgery Reports** ☐ **Pathology reports**
☐ **Copies of most recent MRI and/or CT-Nuclear Medicine** ☐ **History & Physical** (or most recent clinical notes or dictation)

Brookings Health System Central Scheduling 300 22nd Ave Brookings SD 57006 Phone: 605-696-8888 FAX:605-696-8889

Time:_____ **Date:**_____ **Physician Signature:**_____