

Positron Emission Tomography (PET) REQUEST ORDER: Please fill out completely and write legibly.

Please FAX to: (206) 597-4004 Scheduling: (206) 598-4240

Clinic _____
 Routine Today Out-Patient In-Patient

Please contact us to schedule exams less than 24 hour

Primary Insurance _____

Insurance Auth # _____

Secondary Insurance _____

Today's Date: _____ Time: _____

Patient's Phone #: _____

To be scheduled on: _____

- Clinic to call to schedule
 Patient will call to schedule
 Nuc Med to call patient to schedule

REASON FOR EXAM: SPECIFIC SIGNS/SYMPTOMS, RELEVANT HISTORY, AND PRIOR EXAMS

COMPARISON IMAGING STUDIES:

(type, where and when)

PET / CT

FDG scan: Mid-Body Brain only Whole Body

PET Axumin Ga-68 Dotatate

* Noncontrast CT portion of PET/CT exam is for image calibration and is not a diagnostic CT (no IV contrast, no breath hold). * No separate CT report.

For a diagnostic CT exam, select box to the right.

For Diagnostic CT:

(Separate CT report, option of oral and/or intravenous contrast)

IV Contrast? Yes No

Area to scan: Head Neck Chest

Abdomen Pelvis

If ordering IV Contrast CT, Complete this section:

Contrast/Iodine Allergy Yes No

Dialysis Yes No

History of myeloma or asthma Yes No

Creatinine _____ Date _____

If patient is diabetic, over 75, or has a history of kidney disease, a recent creatinine level will be needed within 2 weeks.

Can be drawn in Radiology before exam.

Abnormal Renal Function Yes No

History of Renal Compromise Yes No

Taking Glucophage (Metformin) Yes No

ALLERGIES _____ Latex Allergy Yes No

Interpreter Language _____ Isolation Precaution Yes No

PREGNANT Yes No Patient Weight _____ Type: _____

INCONTINENT Yes No DIABETES Yes No Reason: _____

PLEASE **PRINT** ATTENDING PHYSICIAN (FIRST / LAST NAME REQUIRED) _____

PLEASE **PRINT** ORDERING MD (FIRST / LAST NAME REQUIRED) _____

ORDERING MD SIGNATURE _____ MED STAFF ID# _____ BEEPER# _____

QUESTIONS REGARDING EXAM REQUEST, CONTACT: NAME: _____ PHONE: _____

For Research Studies- Research code # is required prior to scheduling

P.I. _____ Pager _____ Budget # _____ Research RG# _____

PLACE PATIENT LABEL HERE

UW Medicine

Harborview Medical Center – University of Washington Medical Center

UW Neighborhood Clinics – Valley Medical Center

University of Washington Physicians Seattle, Washington

PET REQUEST ORDER

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**FOR SCANNING BY RADIOLOGY
INTO THE RADIOLOGY
INFORMATION SYSTEM**

UH3065 REV MAY 20