

**PET SCHEDULING FORM**

**DX Code(s):** \_\_\_\_\_ **Diagnosis:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **MIMA #** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Patient Diabetic?**     YES     NO                      **On Insulin?**  YES     NO

**Claustrophobic?**     YES     NO

**Problems Lying Still / Flat?**     YES     NO

**PLEASE HAVE PREVIOUS FILMS REQUESTED PERTAINING TO TEST**

**CT EXAM:** \_\_\_\_\_ **CT EXAM DATE:** \_\_\_\_\_

**MRI EXAM:** \_\_\_\_\_ **MRI EXAM DATE:** \_\_\_\_\_

**INSURANCE COMPANY:** \_\_\_\_\_

<b>CPT</b>	<b>ICD-9 DESCRIPTION</b>
78608	PET; without CT Brain (Dementia Evaluation)
78811	PET; without CT single organ (Limited)
78812	PET; without CT cancer evaluation (Eye to Thigh)
78813	PET; without CT melanoma evaluation (Head to Foot)