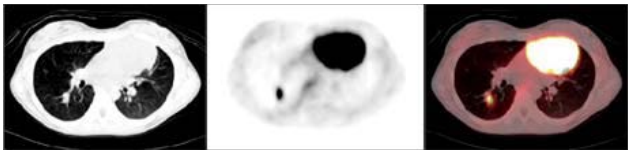
PROVIDENCE
IMAGING CENTER
3340 Providence Drive • Anchorage, AK 99508 • www.provimaging.com
(907) 212-2879 Direct • (907) 212-5828 Fax • Toll-free phone (888) 458-3151 ext. 2879


CT PET PET/CT

PET-CT REQUISITION FORM

DATE _____

PATIENT'S LAST NAME	FIRST NAME	DATE OF BIRTH	GENDER	
			❑ MALE ❑ FEMALE	
HOME PHONE	**WORK PHONE**	**CELL PHONE**	**HEIGHT**	**WEIGHT**
REFERRING CLINICIAN		**SEND ADDITIONAL COPIES OF REPORT TO:**		

Clinical terms/history/symptoms: include specificity requirements, i.e. laterality, location, underlying disease, etc. that **support ICD-10 codes (REQUIRED):**	**ICD-10 codes** that **support clinical terms/history/ symptoms (REQUIRED):**

DIABETIC? ❑ YES ❑ NO INSULIN DEPENDENT ❑ YES ❑ NO

Special Accommodations? (ie. wheelchair/walker; anxiety; top of skull; "hard stick") _____

PET-CT FUSION SCAN*

❑ Routine PET-CT 78815
(skull base to mid thigh)

❑ Whole Body PET-CT 78816
(top of skull to toes)

❑ PET-CT Bone Scan 78816

❑ Brain PET-CT 78814

REASON FOR SCAN

❑ Initial Staging

❑ Diagnosis

❑ Suspected recurrence

❑ Tumor monitoring

❑ Restaging

TREATMENT

Is patient currently doing treatment (Circle one): Yes No

RADIATION	
CHEMOTHERAPY	
SURGERY	

DATE AND LOCATION OF RECENT IMAGING STUDIES**

EXAM	DATE	LOCATION

* If you require any additional imaging ie. CT, MRI, ultrasound, please fill out a separate PIC order form.
As a reminder, every PET-CT done at PIC includes a non-contrast, low dose CT scan automatically fused with the PET images.

** Please make arrangements to have copies of images and reports forwarded to PIC. Reports can be faxed to (907) 212-5828.

CLINICIAN SIGNATURE: _____

revised 10/15