



The PET Center **Toll Free: 1-866-JHU 4 PET**
 600 N. Wolfe St. **(1-866-548-4738)**
 Nelson B1-150 **Local: (410) 955-7226**
 Baltimore, MD 21287-2179 **Fax: 443-287-2557**

JHH History Number _____

Patient's Name (LAST, First, M.I.) _____

Date of Birth _____

CLINICAL PET/CT REQUISITION

Version 2010-08

Please Schedule Prior to/On: _____

Patient: **wt:** _____ kg / lbs **ht:** _____ cm / in

Ordering Physician: (PRINT) _____ CD Requested? No Yes

Ordering Physician Signature: _____ Tel/Pgr: _____ Fax: _____

Patient Address: _____

City/State/Zip: _____

Tel. #s: Home: _____ Work: _____ Cell: _____

Clinical Dx/Relevant Findings: _____

_____ Any special region of interest? _____

Diabetic? No Yes: Meds _____ **Claustrophobic?** No Yes (Consider premedication.)

Oncology (¹⁸F DG ¹¹C acetate): Initial Dx/Unknown 1°/Staging Subsequent/Tx Monitoring

Date of LAST: Chemotherapy: _____ Radiation Therapy: _____ Surgery: _____

G-CSF: _____ Biological Tx: _____ Biopsy: _____

RESULTS: CT/MRI: _____ Seromarker: _____

Infection/Inflammation: ¹⁸F DG _____

Brain: ¹¹C methionine ¹⁸F DG: EEG monitoring? No Yes _____

Cardiac: Perfusion Rest, Stress Rest only add Viability (¹⁸F DG) add CT Angio Sarcoid protocol

Other PET Tracer: ¹⁸F bone scan Other: _____

NOTE: All PET/CT at JHH includes a reduced-radiation CT without iodinated IV contrast (oral dilute barium only). Standard CT with IV contrast can be added as an additional test while on the PET/CT scanner. SINGLE-PHASE EXAM ONLY. Please refer to CT division for multi-phase or 3D studies.

← Check to add *single-phase IV contrast CT*, and mark the area of interest. No iodinated IV Contrast

Brain/Head Neck Chest Abdomen/Pelvis Extremities

Serum Creatinine _____ **Date of serum Cr:** _____ (please have within 2 mo prior to scan)

Contrast allergy? No Yes (Must premedicate.) History of Myeloma? No Yes

INSURANCE INFORMATION: (In order to facilitate scheduling, please fill out ALL information)

Company Name: _____ Tel: _____

Company Address: _____

Patient's Group Number: _____ Membership Number: _____

Cardholder's Name: _____

PLEASE PHOTOCOPY FRONT & BACK OF MEDICAL CARD FOR VERIFICATION