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** ☐**F-18 PSMA PYLARIFY**

** 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

Abnormal Renal Function ☐ Yes ☐ No

History of Renal Compromise ☐ Yes ☐ No

Taking Glucophage (Metformin) ☐ 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.**

☐ **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 Medicine Primary Care – Valley Medical Center – UW Physicians

PET REQUEST ORDER

U3065

UH3065 REV JUL 22