



Please fill this form out completely, attaching any insurance pre authorizations and pertinent chart notes. Fax all information to us at (541) 382-6635 so we may start the scheduling process for your patient. Please allow up to two weeks for a patient appointment to be scheduled. We will contact the patient to schedule their appointment, and contact you at the number you provide to inform you of the scheduled date and time. PET scans are done every Monday and Wednesday morning at St. Charles Medical Center. Thank you for your referral.

PET EXAM TO BE SCHEDULED (please check one): ONCOLOGY BRAIN CARDIAC

PATIENT INFORMATION

Pt Name: _____ D.O.B. ____/____/____ Age: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Patient Home 📞 (____) _____ Work 📞 (____) _____ Cell 📞 (____) _____

Patient Weight: _____ Height: _____ Male Female SS#: _____ - _____ - _____

Primary Insurance: _____ Secondary Insurance: _____

PLEASE PROVIDE US WITH A COPY OF THE PATIENT'S INSURANCE CARD (Front and Back)

Ref. Phy. Signature: _____ **Print Ref. Phy Name:** _____

Referring Physician 📞 (____) _____ Referring Physician Fax: (____) _____

Please send a CC of the results to: _____

Does the Patient Have any Special Needs (e.g., deaf, blind, interpreter)? Yes No

If Yes What are they? _____

CLINICAL INFORMATION

Diagnosis: _____ ICD9 code(s): _____

Clinical Indication/Questions to be Answered: _____

If Pre-Authorization is denied by the Patients' Insurance Company, what other course of action will you take? _____

Is the Patient Diabetic? Yes No

If Yes, how its it controlled? Diet Oral Meds Insulin **Blood Sugar Level:** _____

SUPPORT DOCUMENTATION

A COPY of the H & P and CHART NOTES are REQUIRED.
PERTINENT PREVIOUS EXAMS

	Date	Location Performed		Date	Location Performed
Nuc Med	____/____/____	_____	CARDIAC ONLY:		
CT	____/____/____	_____	Cardiac Echo	____/____/____	_____
MRI	____/____/____	_____	Cardiac Cath	____/____/____	_____
Op & Path (Lung Only)	____/____/____	_____	Cardiac Spect	____/____/____	_____

For CMI Use Only:			
Date Scheduled: ____/____/____	By: _____	Appointment Date: ____/____/____	Time: ____:____:
Patient Info. Sent: <input type="checkbox"/>	Referring Office Informed of Appointment: <input type="checkbox"/>	Auth#: _____	