UCLA Health

MRN:
Patient Name:

(Patient Label)

PET/CT REQUEST FORM

Print | Clear Form

Date of Request:_____

Height_____ ☐ in ☐ cm Weight_____ ☐ lbs ☐ kg

Iodine or other Allergies: _____ ☐ None

Primary Diagnosis:_____ICD10:_____

Pertinent clinical history:

PURPOSE OF PET/CT

Please specify one: ☐ Initial Treatment Strategy ☐ Subsequent Treatment Strategy

Please select the appropriate procedure:

☐ **PET/CT (base of skull to upper thigh) and Diagnostic CT <u>with</u> IV contrast of:**
☐ **Neck** ☐ **Chest** ☐ **Abd** ☐ **Pelvis** ☐ **Lower Extremities** ☐ **Upper Extremities**

*For Diagnostic CT, please provide most recent Creatinine Levels:_____Date: _____
(Note: Serum Creatinine level within 6 weeks of the scheduled PET/CT scan appointment is required)

☐ **PET/CT Brain only**

☐ **PET/CT (base of skull to upper thigh) and Diagnostic CT <u>without</u> IV contrast of:**
☐ **Neck** ☐ **Chest** ☐ **Abd** ☐ **Pelvis** ☐ **Lower Extremities** ☐ **Upper Extremities**
(CT without IV contrast because of medical contraindication to IV contrast)

☐ **PET/CT (base of skull to upper thigh) CT only for localization & attenuation correction***

Referring MD:_____ID#/UPIN _____
Asst: _____Phone #:(____)_____Fax #:(____)_____
Address: _____
Patient Insurance: _____Authorization: _____

NUCLEAR MEDICINE NOTES AND PRESCRIPTIONS

RIS LABEL HERE

Prescription:
Adult Patient: 0.21 mCi/kg 18-FDG up to 22 mCi
Pediatric Patient: 0.14 mCi/kg 18-FDG up to 15 mCi

MD Signature _____
Pager/ID #: _____
Print Name: _____
Date_____ Time_____

Comments:

Westwood: 200 Medical Plaza, Suite B114, Los Angeles, CA 90095 | Phone: (310) 794-1005 Fax: (310) 267-0227
Santa Monica: 1245 - 16th Street, Suite 105, Santa Monica, CA 90404 | Phone: (310) 319-4970 Fax: (310) 319-4980
Santa Clarita: 27235 Tourney Rd., Santa Clarita, CA 91355 | Phone: (310) 301-6800