



# PET/CT Imaging Request Form

3195 Folsom Boulevard - Sacramento, CA 95816-5233  
Phone: 916-737-3211 or 888-738-3211  
Fax: 916-737-6203

*Ordering Guidelines and Patient Prep Information on Reverse*

PLEASE COMPLETE ALL SECTIONS OF THIS FORM

Please Call Patient to Schedule

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Insurance: \_\_\_\_\_  
Policy#: \_\_\_\_\_ Auth#: \_\_\_\_\_  
Referring MD: \_\_\_\_\_ Contact: \_\_\_\_\_  
Ph: \_\_\_\_\_ Fax: \_\_\_\_\_  
cc: \_\_\_\_\_

DOB: \_\_\_\_\_  
Gender:  M  F  
HT: \_\_\_\_\_ WT: \_\_\_\_\_  
Diabetic  Y  N  
Claustrophobic  Y  N  
Fax: \_\_\_\_\_

**LOCATION:**

- Midtown Sacramento**  
3195 Folsom Blvd., 95816
- Auburn**  
11785 Education St, 94533
- Grass Valley**  
155 Glasson Way, 95945
- Lincoln**  
1 Medical Plaza, 95661
- Vallejo**  
300 Hospital Drive, 94589
- Woodland**  
1325 Cottonwood St., 95695

**APPT DATE/TIME:** \_\_\_\_\_

**PET/CT** *(Concurrent Diagnostic CT can be requested below)*

- Standard PET/CT** 78815 + A9552
- Axumin Prostate PET/CT** 78815 + J3490
- Whole Body PET/CT** 78816 + A9552
- Molecular Breast Imaging (MBI)**  
(Prone Breast PET/CT) 78814 + A9552
- F-18 BONE PET/CT Scan**
  - Oncology 78816 + A9580
  - Ortho 78814 + A9580 Area: \_\_\_\_\_

- BRAIN**
  - Metabolism (FDG) 78608
  - Amyloid Plaque 78814
    - Amyvid A9586
    - Neuraceq Q9983
- CARDIAC** 78492
  - Myocardial Viability
  - Myocardial Perfusion Rest & Stress  
*(Please call for special scan preparation)*

**DIAGNOSTIC CT** *(Contrast CT performed at Midtown location only)*

Area of Interest \_\_\_\_\_ CONTRAST:  Without  With\*  With\* & Without  
\*with Contrast - BUN \_\_\_\_\_ Creatinine \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT HISTORY**

Primary Tumor: \_\_\_\_\_  Initial TX / Staging  Subsequent TX / Re-Staging

**MEDICAL NECESSITY STATEMENT:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMAGING TABLE:**

- Standard** - curved for patient comfort *(default)*
- Flat** - for radiotherapy planning

For more information visit our website:  
[www.NorCalScans.org](http://www.NorCalScans.org)

SIGNATURE of Referring Physician: \_\_\_\_\_ Date: \_\_\_\_\_

*(Required)*