

Campbell Office Plaza • 3503 N. Campbell Ave., Suite 155, Tucson AZ, 85719 • Phone (520) 321-4057 • Fax (520) 321-4061  
 Toll Free - outside of Tucson 1-877-797-3829

**PATIENT REFERRAL**

Name \_\_\_\_\_ Primary Diagnosis \_\_\_\_\_ ICD-9 Code \_\_\_\_\_

Other History \_\_\_\_\_

**PET/CT EXAM REQUESTED**

- |   |   |
|---|---|
| <input type="checkbox"/> 78815 Skull base to mid thigh (lymphoma, lung, breast, colon, GI, head & neck) | <input type="checkbox"/> 78459 Myocardial viability                     |
| <input type="checkbox"/> 78816 Whole body (melanoma, renal cell)  | <input type="checkbox"/> 78608 Brain <input type="checkbox"/> 95816 EEG |

► **REFERRING PHYSICIAN** (*signature required*) \_\_\_\_\_ Date: \_\_\_\_\_  
 (*please print name*) \_\_\_\_\_

Contact Person \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

► **PATIENT INFORMATION**

DOB \_\_\_\_\_  Male  Female    SSN \_\_\_\_\_    Telephone# \_\_\_\_\_

Address (*city, state & zip code*) \_\_\_\_\_

Height \_\_\_\_\_    Weight (*450 lbs max wt limit*) \_\_\_\_\_

► **PREVIOUS STUDIES?**

- CT &/or MR (*fax report*) \_\_\_\_\_
- PET scan (*fax report*) \_\_\_\_\_
- Other (*fax report*) \_\_\_\_\_

Pathology (*fax report which supports clinical indication*) \_\_\_\_\_

Surgeries / Biopsies (*fax report*) \_\_\_\_\_

Radiation Therapy &/or Chemotherapy (when was last treatment or when will it begin)? \_\_\_\_\_

► **INSURANCE INFORMATION**

Primary Insurance \_\_\_\_\_ ID# \_\_\_\_\_

Primary Ins. Phone # \_\_\_\_\_

*(please fax copy of patient's insurance card if possible)*

Secondary Insurance \_\_\_\_\_ ID# \_\_\_\_\_

Secondary Ins. Phone # \_\_\_\_\_

**Thank You For Referring Your Patient To Southwest PET/CT Institute!**