PET/CT IMAGING
OF BERKELEY
2855 Telegraph Ave., Suite 100, Berkeley, CA 94705
AMERICAN COLLEGE OF RADIOLOGY ACCREDITED PET AND CT FACILITY

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Patient Information

Patient Name:_____ DOB: _____ Tel:_____

Patient's Insurance:_____ Insurance ID#:_____

Auth#:_____Auth valid dates:_____ **Is patient diabetic? □ YES □ NO**

Physician Information

Ordering Physician: _____ Tele:_____ Date:_____

Diagnosis & Symptoms (site specific):_____

ICD-10:_____ Physician Signature:_____-_____

PET/CT REFERRAL

□ **78815** - Skull Base to Mid Thigh
□ **78816** - Whole Body
□ **78608** - Brain

□ FDG
□ Axumin
□ Other _____

Questions

Is patient currently undergoing treatment? □ Chemotherapy □ Radiation Therapy

Has the patient had a previous PET or PET/CT scan? □ Yes □ No

If yes, list when and where:_____

DIAGNOSTIC CT REFERRAL

Contrast? □ With □ Without □ With & Without

□ Brain
□ Neck
□ Chest
□ Abdomen/Pelvis

□ Abdomen Only
□ Pelvis Only
□ Sinus
□ Spine C T L (please choose)

□ Other: _____

□ CT coronary calcium scoring
□ CT Coronary angiogram
□ CT angiography

*** GFR & creatinine needed for studies with IV contrast**

Please FAX to our office

1. Patient Information/registration sheet
2. Insurance cards-both sides
3. Recent PET/CT/MRI/Pathology reports
4. History

Report Information

□ **STAT**
□ **Fax Report: #**_____
□ **Phone Report: #**_____
□ **Email report to:**_____