DIAGNOSTIC CT EXAMINATION

Appointment Info:

Date: ____________________

Time: ____________________

Patient Info:

Patient's Name: ____________________ SS#: ____________________

Address: ____________________ City: ____________ State: ________ Zip: ____________

DOB: ____________________ Best Phone #: ____________________

Any Recent Surgeries/Biopsies: ____________________

Physician Info:

Referring Physician: ____________________ Special Instructions (STAT): ____________________

Office Fax: ____________________ Phone: ____________________

Physician Signature: ____________________

Diagnostic CT Scan(s)

Please circle diagnostic CT scan (s) desired/ DX:

1. Head with OR without IV contrast
2. Neck with IV contrast
3. Chest with IV contrast (except solitary lung nodule or HRCT)
4. Abdomen with or without IV contrast
5. Pelvis with or without IV contrast
6. CT Urogram (No IV); Paranasal Sinuses (No IV); Liver Hemngioma Protocol (IV); Aortic Dissection or Pulmonary Embolus Protocol
7. Other: ____________________

Special CT Procedures

Please circle scan (s) desired/ DX: ____________________

1. CT Coronary Angiography (CTA)
2. Virtual Colonoscopy (VC)
3. Peripheral Vessel Angiography

BUN: ____________ Creatinine: ____________ Not Available: ____________ Date of lab work: ____________

Please Fax Copy to (352) 795-7843 - Thank You
PHONE: 352-795-0847

Clinical P.E.T.
OF CITRUS AT MEADOWCREST
6140-6142 W. Corporate Oaks Drive
Crystal River, FL 34429
www.clinicalpet.com

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UF UNIVERSITY of FLORIDA
College of Medicine

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