

DIAGNOSTIC CT EXAMINATION

With 64 Slice CT Scanner

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: _____

64 Slice 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 Hemangioma 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: _____



Clinical P.E.T.
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Please Fax Copy to (352) 387-1230 - Thank You
PHONE: 352-861-4602

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UF UNIVERSITY of
FLORIDA
College of Medicine



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