

# 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 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.**  
OF HERNANDO

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**PHONE: 352-688-2505**

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**FLORIDA**  
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