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 www.clinicalpet.com

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: _____

PET Scan

Lung Cancer (non small cell only)

- Diagnosis
- Initial Staging
- Restaging
- Solitary Pulmonary Nodule

Lymphoma

- Diagnosis
- Initial Staging
- Restaging

Melanoma

- Diagnosis
- Initial Staging
- Restaging

Colorectal Cancer

- Diagnosis
- Initial Staging
- Restaging

Breast Cancer

- Staging/Recurrence
- Evaluation of Response to treatment

Esophageal Cancer

- Diagnosis
- Initial Staging
- Restaging

Cervical Cancer

- Diagnosis
- Initial Staging
- Restaging

Head & Neck Cancer

- Diagnosis
- Initial Staging
- Restaging

Thyroid

- Staging
- Restaging

Alzheimer's Diagnosis

- Myocardial Viability
- Refractory Seizures

Other: _____ Diagnosis or DX Code: _____

Comparison Films: <i>(very important)</i>	Date:	Location:
PET		
CT		
MRI		
OTHER		

**Please Fax Copy to (813) 788-1973
 Thank You**