FLORIDA CANCER SPECIALISTS & Research Institute

(855) 327-6003 • Fax: (855) 314-6973

Patient Name _____ Date Ordered _____

Address _____ DOB_____ Phone _____

Male ☐ Female ☐ Insurance Provider _____Insurance ID# _____

Prior Scan ☐ Yes ☐ No *(If patient had prior scan, please attach)*

PLEASE ATTACH COPY OF INSURANCE CARDS & RECENT OFFICE VISIT NOTE WITH THIS FORM

Requested Date of Exam _____ ICO-10 Codes_____

Reason for Exam _____

PET/CT SCAN: Please select ☐ Initial Treatment Strategy ☐ Restaging

☐ Skull Base to Mid-Thigh

☐ Whole Body (For Melanoma, Multiple Myeloma, Merkel Cell)

☐ Axumin Skull to Mid-Thigh

☐ Pet Brain- Metabolic FDG

☐ Florbetapir F18 PET Scan (Gladiolus Only)

☐ Detectnet (Cu64) Scan

☐ NAF-18 (Bone) Scan Whole Body

☐ Pylarify - PSMA (Certain Locations)

CT SCAN: All CT scans require a Creatinine and EGFR level within the last 30 days for patients with Diabetes and/ or Kidney Issues.

☐ **Abdomen**
☐ With ☐ W/O ☐ With & W/O
☐ Oral Contrast

☐ **Cervical Spine**
☐ With ☐ W/O ☐ With & W/O
☐ Oral Contrast

☐ **Chest, Abdomen, Pelvis**
☐ With ☐ W/O ☐ With & W/O
☐ Oral Contrast

☐ **Maxillofacial**
☐ With ☐ W/O ☐ With & W/O
☐ Oral Contrast

☐ **Thoracic Spine**
☐ With ☐ W/O ☐ With & W/O
☐ Oral Contrast

☐ **Abdomen Triple Phase W Pelvis W Contrast**
☐ With & W/O ☐ Oral Contrast

☐ **Abdomen, Pelvis**
☐ With ☐ W/O ☐ With & W/O
☐ Oral Contrast

☐ **Chest**
☐ With ☐ W/O ☐ With & W/O
☐ Oral Contrast

☐ **Lower Extremity**
☐ With ☐ W/O ☐ With & W/O
☐ Left ☐ Right ☐ Upper
☐ Lower ☐ Both ☐ Oral Contrast

☐ **Neck**
☐ With ☐ W/O ☐ With & W/O
☐ Oral Contrast

☐ **Upper Extremity**
☐ With ☐ W/O ☐ With & W/O
☐ Left ☐ Right ☐ Upper
☐ Lower ☐ Both ☐ Oral Contrast

☐ **Brain**
☐ W/O ☐ With & W/O ☐ Oral Contrast

☐ **Chest, Abdomen**
☐ With ☐ W/O ☐ With & W/O ☐ Oral Contrast

☐ **Lumbar Spine**
☐ With ☐ W/O ☐ With & W/O
☐ Oral Contrast

☐ **Pelvis**
☐ With ☐ W/O ☐ With & W/O
☐ Oral Contrast

☐ **Abdomen Triple Phase**
☐ With & W/O
☐ Oral Contrast

ALLERGY TO IODINE
☐ Yes ☐ No
Allergy Med Given: _____

Referring Physician Name_____ Phone #_____

Signature _____ Fax # _____