# UCLA PET/CT REQUEST FORM

**Date of Request:**

Height: ___________ □ in □ cm Weight: ___________ □ kg □ lbs

Iodine or other Allergies: ____________________________

Primary Diagnosis: ____________________________

ICD9: ____________________________

Pertinent clinical history ____________________________

## Purpose of PET/CT

Please specify one: □ Initial Treatment Strategy □ Subsequent Treatment Strategy

Please select the appropriate procedure:

| □ PET/CT (base of skull to upper thigh) and Diagnostic CT with IV contrast of: | □ Neck □ Chest □ Abd □ Pelvis □ Lower Extremities □ Upper Extremities |
| *For Diagnostic CT, please provide most recent Creatinine Levels: ___________ Date: ___________ |
| (Note: Serum Creatinine level within 6 weeks of the scheduled PET/CT scan appointment is required) |

| □ PET/CT Brain only |
| □ PET/CT (base of skull to upper thigh) and Diagnostic CT without IV contrast of: |
| □ Neck □ Chest □ Abd □ Pelvis □ Lower Extremities □ Upper Extremities |
| (CT without IV contrast because of medical contraindication to IV contrast) |

| □ PET/CT (base of skull to upper thigh) Non-Diagnostic CT (used only for localization & attenuation correction) |

**Referring MD:** ____________________________

**ID#/UPIN:** ____________________________

**Asst:** ____________________________

**Phone #:** (______) ____________________________

**Fax #:** (______) ____________________________

**Address:** ____________________________

**Patient Insurance:** ____________________________

**Authorization:** ____________________________

## NUCLEAR MEDICINE NOTES AND PRESCRIPTIONS

### Prescription:

- Adult Patient: 0.14mCi/kg 18-FDG up to 22mCi
- Pediatric Patient. 0.1mCi/kg 18-FDG up to 15mCi

**RIS LABEL HERE**

**MD Signature** ____________________________

**Beeper/ID #** ____________________________

**Print Name** ____________________________

**Date/Time** ____________________________

**Comments:**

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