

# COLUMBUS CIRCLE IMAGING

A division of West Side Radiology Associates, P.C.

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PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_ ACC# \_\_\_\_\_ TIME: \_\_\_\_\_ ID# \_\_\_\_\_

WHOLE BODY PET \_\_\_\_\_ CARDIAC PET \_\_\_\_\_ BRAIN PET \_\_\_\_\_

THE REASON FOR PET: \_\_\_\_\_

HISTORY: \_\_\_\_\_

PRIOR PET? YES\_\_\_ NO\_\_\_ IF YES, WHERE? \_\_\_\_\_ WHEN? \_\_\_\_\_

DIABETIC? YES\_\_\_ NO\_\_\_ IF YES, MEDICATIONS? \_\_\_\_\_

STEROIDS? YES\_\_\_ NO\_\_\_ CHEMO? YES\_\_\_ NO\_\_\_ RADIATION YES\_\_\_ NO\_\_\_

IF YES, START DATE: \_\_\_\_\_ COMPLETION DATE: \_\_\_\_\_

RECENT CT'S OR MRI'S? YES\_\_\_ NO\_\_\_ WHERE? \_\_\_\_\_ WHEN? \_\_\_\_\_

IF FEMALE OF CHILD BEARING AGE, IS THERE A POSSIBILITY OF PREGNANCY? YES\_ NO\_

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE HOME # \_\_\_\_\_ WORK \_\_\_\_\_

INSURANCE: \_\_\_\_\_ PRE AUTH: \_\_\_\_\_

POLICY/ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

PATIENT'S HEIGHT? \_\_\_\_\_ PATIENT'S WEIGHT? \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ASK THE PATIENT THE SIDE OF INVOLVEMENT AND INJECT THE CONTRALATERAL ARM INJECTION SITE: \_\_\_\_\_