BRAIN PET REFERRAL DATA SHEET
NON-ONCOLOGY (Dementia, Seizures, etc.)
Biomedical Research Foundation of Northwest Louisiana
Positron Emission Tomography (P.E.T.) Imaging Center
Scheduling Phone: 318-675-4042 Fax: 318-675-4020
Toll Free: 1-888-685-1152

PATIENT NAME: _____
print

PHYSICIAN: _____ _____
print signature of referring physician

PRIORITY (circle one):
ROUTINE (for restaging and follow up scans)
ASAP (for staging, treatment or surgery planning)
SPECIFIC DATE: _____

DIAGNOSIS (include histology and date):
_____
_____
_____

PRIOR WORKUP (MRI, CT, EEG):
PRIOR/ONGOING RX:
_____
_____
_____
_____
_____
_____

REASON FOR SCAN (DESIRED INFORMATION): _____
_____
_____

In order to provide you with the maximum possible information from your patient's PET/CT scan, it is critical that the clinical data on this form be available to the physician at the time of the study. It should be supplemented with copies of an appropriate history and physical or clinical notes, copies of recent diagnostic imaging reports and relevant laboratory data (e.g. tumor marker levels), as well as results of recent biopsy or surgical pathology. ***Patients cannot be scheduled without the information on this form being complete and signed by the referring physician (required by CMS (Medicare) and private insurance carriers.***

Person faxing information: _____ **Phone #** _____