



Today's Date: _____

COLUMBIA UNIVERSITY COLLEGE OF PHYSICIANS AND SURGEONS

Patient's Name _____ Social Security Number _____

Home Phone () _____ Date of Birth _____ Age _____ Sex _____ Height _____ Weight _____

Work Phone () _____ Insurance _____ Insurance Identification # _____

Referring Physician _____ Medical Specialty _____

Physician's Address _____

UPIN# _____ License # _____

Phone Number: () _____ Fax: () _____ E-mail: _____

Send additional copy of report to

Name of Physician _____

Address _____

Type of PET Scan Requested

- Cardiac Perfusion – Rest (Rb-82) and Stress (Rb-82 with adenosine)
- Cardiac Perfusion – Rest (N-13) and Stress (N-13 with adenosine)
- Cardiac Viability – Rest (Rb-82) Perfusion and Metabolism (FDG)
- Cardiac Viability – Rest (N-13) Perfusion and Metabolism (FDG)
- Cardiac Sarcoidosis – Metabolism (FDG)

Reason for PET Scan _____

Medical Diagnosis _____

Relevant Medical History

- | | | | |
|-------------|--|------------|--|
| Known CAD | <input type="checkbox"/> Yes <input type="checkbox"/> No | CABG | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| MI | <input type="checkbox"/> Yes <input type="checkbox"/> No | Transplant | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HTN | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| CHF | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angioplasty | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Current Medications _____

Previous Studies

- | | | | |
|-------------------------|--|-------------------|--|
| Cardiac Perfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cardiac Viability | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Catheterization | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thallium Scan | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**If Yes, please fax any and all results with this from to 212-923-2821.
Please send original scans with the patient on the day of the appointment.**

Signature of Referring Physician _____

FOR INTERNAL USE ONLY: CPMC Medical Record # _____