



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: _____

Reason for PET Scan/Clinical Question: _____

Type of PET Scan requested: Brain

Is patient pregnant? Yes No Date of Last Menses _____ Breast Feeding? Yes No

Relevant Medical History: _____

For Alzheimer's:

Current Medications: _____

Date of Onset of Symptoms: _____

History of Cerebrovascular Disease: _____

Date and Score MiniMental Status Exam: _____

Other Neuropsychological Testing: Yes No Results: _____

B12 and Thyroid Hormones Test: Yes No Results: _____

Date and Location of MRI or CT scan: _____ Normal Abnormal Explain: _____

Has a SPECT been Performed?* Yes No Date/Location: _____ Normal Abnormal

Explain: _____

**Please note: CMS does not approve reimbursement for PET Scans for the diagnosis of Alzheimer's disease if a SPECT scan has already been performed.*

For Seizure Disorders:

EEG Findings: _____

Date and Location of MRI or CT scan: _____ Normal Abnormal Explain: _____

Has a SPECT been Performed?* Yes No Date/Location: _____ Normal Abnormal

Explain: _____

Surgery: _____

Medications: _____

Date of last seizure: _____

For Brain Tumors:

For Medicare coverage of PET imaging of brain tumors, patient must be enrolled in Medicare's NOPR study. To learn more: www.cancerpetregistry.org.

Cancer Treatment: Radiation Therapy (RT) Chemotherapy

Date of completion: _____ Name of drug: _____

Date of most recent cycle completion: _____

Date and Location of MRI or CT scan: _____ Normal Abnormal Explain: _____

Other Medications: _____

Signature of Requesting Physician: _____

Questions about PET? Call 212.923.1555

Please fax requisition form back as soon as possible. Fax: 212.923.2821

Under recent privacy legislation known as HIPAA, the referring physician is responsible for informing the patient of the Notice of Privacy Practices.

We assume this task has been done. Please notify us if it has not.

FOR INTERNAL USE ONLY: CUMC Medical Record # _____