DIAGNOSTIC CT EXAMINATION

Appointment Info:

Date: ______________________

Time: ______________________

Patient Info:

Patient's Name: ______________________ SS#: ______________________

Address: ______________________ City: ______________ State: ________ Zip: ______________

DOB: ______________________ Best Phone #: ______________________

Any Recent Surgeries/Biopsies: ______________________

Physician Info:

Referring Physician: ______________________ Special Instructions (STAT): ______________________

Office Fax: ______________________ Phone: ______________________

Physician Signature: ______________________

Diagnostic CT Scan(s)

Please circle diagnostic CT scan (s) desired/ DX:

1. Head with OR without IV contrast
2. Neck with IV contrast
3. Chest with IV contrast (except solitary lung nodule or HRCT)
4. Abdomen with or without IV contrast
5. Pelvis with or without IV contrast
6. CT Urogram (No IV); Paranasal Sinuses (No IV); Liver Hemngioma Protocol (IV); Aortic Dissection or Pulmonary Embolus Protocol
7. Other: ______________________

Special CT Procedures

Please circle scan (s) desired/ DX: ______________________

1. CT Coronary Angiography (CTA)
2. Virtual Colonoscopy (VC)
3. Peripheral Vessel Angiography

BUN: ____________ Creatinine: ____________ Not Available: ____________ Date of lab work: ____________

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Leesburg, FL 34748
www.clinicalpet.com

Please Fax Copy to (352) 314-2698 - Thank You
PHONE: 352-314-2945

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UF UNIVERSITY of FLORIDA
College of Medicine

Rev. 12/06

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