MYOCARDIAL PERFUSION PET/CT REFERRAL DATA SHEET
NON-ONCOLOGY (Dementia, Seizures, etc.)

Please note new location and contact information for CMIT

Center for Molecular Imaging and Therapy
2120 Kings Highway
Scheduling: 318-716-4001
Fax: 318-716-4075

PATIENT NAME: _____
print

PHYSICIAN: _____ _____
print signature of referring physician

PRIORITY (check one): _____ **ROUTINE** _____ **ASAP** _____ **SPECIFIC DATE**: _____

TYPE OF STUDY (circle one): _____ **EXERCISE** _____ **PHARMACOLOGIC**

DIAGNOSIS: _____

SYMPTOMS (circle all that apply): Chest Pain SOB Other (specify)_____

PERTINENT HISTORY (circle all that apply): CAD Hypertension Hyperlipid DM Asthma

Other Cardiac Risk Factors (specify): _____

CARDIAC MEDICATIONS (list)**:**_____

_____

CARDIAC PROCEDURES IN PAST (circle all that apply): PCI Cath CABG

Other (specify): _____

PATIENT INFO:
BMI (specify): _____

Circle all that apply:

Breast Implants	Contrast Allergy	Prior inclusive or equivocal SPECT
Mastectomy	Renal Dysfunction	
Chest deformity	Pleural or Pericardial Effusion	

I verify that this office has used Appropriate Use Criteria before ordering this PET/CT Scan: ☐ Yes ☐ No

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 #** _____