Columbia Kreitchman **PET** Center

COLUMBIA UNIVERSITY COLLEGE OF PHYSICIANS & SURGEONS

CARDIAC PET REQUISITION FORM

Today's Date:_______________

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 ( ) ____________________

Send additional copy of report to

Name of Physician ______________________________________

Address ______________________________________

Type of PET Scan Requested

☐ Cardiac Perfusion (Rest (N-13) and Stress (N-13 with adenosine) Perfusion)

☐ Cardiac Viability (Rest (N-13) Perfusion and Metabolism (FDG))

Reason for PET Scan ______________________________________

Medical Diagnosis ______________________________________

Relevant Medical History

Known CAD	☐ Yes	☐ No	CABG	☐ Yes	☐ No
MI	☐ Yes	☐ No	Transplant	☐ Yes	☐ No
HTN	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
CHF	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Angioplasty	☐ Yes	☐ No			

Current Medications ______________________________________

Previous Studies

Cardiac Perfusion	☐ Yes	☐ No	Cardiac Viability	☐ Yes	☐ No
Cardiac Catheterization	☐ Yes	☐ No	Thallium Scan	☐ Yes	☐ 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 ______________________________________

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FOR INTERNAL USE ONLY: CPMC Medical Record # ____________________

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