OCMRI
MRI-PET-CT
17150 Euclid Street, Suite 101
Fountain Valley, CA 92708
(714) 957-0317 Fax (714) 957-0616

# PET/CT SCAN

**DATE:** _____

**PATIENT NAME:** _____ _____ CHART NO: _____
**LAST** **FIRST**

**AGE:** _____ **BIRTH DATE:** _____ **SEX:** M / F

**HEIGHT:** _____ **WEIGHT:** _____

REFERRING PHYSICIAN: _____ PHONE: _____

- HAVE YOU HAD ANYTHING TO EAT OR DRINK EXCEPT FOR WATER WITHIN 6 HOURS OF THIS APPOINTMENT? Y / N
- IF YES, WHEN AND WHAT? _____
- WHAT IS THE **REASON** YOUR DOCTOR **ORDERED** THIS **PET** SCAN?
  _____
- DO YOU HAVE A **HISTORY OF CANCER?** IF SO, WHAT TYPE?
  _____
- HAVE YOU HAD A PREVIOUS **PET SCAN**? Y / N
  IF YES, WHERE AND WHEN? _____
- HAVE YOU HAD A **CT SCAN**? Y / N
  IF YES, WHERE AND WHEN? _____
- HAVE YOU HAD **CHEMOTHERAPY OR RADIATION TREATMENT**? Y / N
  IF YES, START AND END DATE: _____
- DIABETES? Y / N ARE YOU ON INSULIN Y / N
- SURGERY OR BIOPSY? Y / N
- RECENT INFECTION? Y / N

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***FOR TECHNOLOGIST TO FILL OUT***

***DOSE ADMINISTERED***: _____ mCi ***BLOOD SUGAR LEVEL***: _____

_____mCi @ _____

INJ. _____@ _____

UPTAKE TIME _____

POST _____mCi @ _____

_____ ml

# PATIENT INFORMATION SHEET

OCMRI
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Chart No. _____

Scan _____

Insurance _____

Date and Time of Appointment: _____

## PATIENT INFORMATION

Patient Name: _____ Driver's License No. _____

Address: _____

City, State Zip: _____ Date of Birth: _____

Telephone (Home): _____ Telephone (Work): _____

Social Security Number: _____

Emergency Contact Name _____ Telephone _____

## REFERRING SOURCE

Doctor: _____ Chiropractor: _____ Other: _____

Name of Referring Source: _____ Telephone: _____

## INSURANCE INFORMATION

Subscriber Name_____ Subscriber SS#:_____

Relation to Patient_____ Policy No._____

**Primary Ins**_____ **Second Ins**_____

Group No._____ Group No._____

Member No._____ Member No._____

Address_____ Address_____

_____ _____

I authorize payment of medical benefits to Orange County MRI for medical services

Signature: _____

I also authorize release of medical information to process any claims

Signature: _____ Date: _____