

DIAGNOSTIC REFERRAL REQUEST

Please complete all fields and fax this to: (614) 548-8340 or call (614) 383-6475.

Copies of this form may be downloaded from: ZangCenter.com

Patient Name: _____ Date: _____

Patient Address: _____
Street Address City State Zip

Home Phone: () _____ Other: () _____

DOB: _____ SS#: _____

Diagnosis/Reason for Testing: _____

Ordering Physician: _____ Staff Contact: _____

Phone: () _____ Fax: () _____

Primary Insurance: _____ Secondary: _____

Authorization #: _____ Valid Dates: _____ to _____

Creatinine: _____ Date: _____

(Recent Creatinine within 30 days of exam date for contrast enhanced CT scans)

PET IMAGING

___ Axumin Prostate _____ PET/Bone
 ___ Tumor Imaging _____ Whole Body
 Skull to Thigh

DIAGNOSTIC PET/CT

(includes a diagnostic CT with or without contrast)

___ Diagnostic PET/CT Skull to Thigh
 ___ Diagnostic PET/CT Whole Body

X-RAY

___ Chest PA/LAT
 ___ Abdomen
 ___ Spine Specify: Cervical Thoracic Lumbar
 ___ Shoulder Specify: L R
 ___ Hip Specify: L R
 ___ Ankle Specify: L R
 ___ Foot Specify: L R
 ___ Metastatic Survey
 ___ Other Specify: _____

BONE MINERAL DENSITY

___ DEXA (includes hips & lumbar)

CT With Contrast Without Contrast

___ Chest Angiogram
 ___ Chest
 ___ Abdomen
 ___ Pelvis
 ___ Head/Brain
 ___ Sinus
 ___ Orbits
 ___ Neck - soft tissue
 ___ Thoracic
 ___ Lumbar
 ___ Lung Screen
 ___ High Res Chest
 ___ Upper Extremity Specify: _____
 ___ Lower Extremity Specify: _____
 ___ Other Specify: _____

NUCLEAR MEDICINE

___ Bone Scan ___ Octreoscan
 ___ Liver Scan ___ MUGA (Multi-Gated Acquisition - Cardiac EF)

Physician Signature: _____ Date: _____