Office: 808.275.2008
Fax: 808.275.2009
500 Ala Moana Blvd, Suite 5B
Honolulu HI, 96813

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
Last Name First Name

Phone: _____ Insurance Type: _____

ULTRASOUND

☐ Abdomen
☐ Pelvic
☐ Thyroid
☐ Renal
☐ Carotid
☐ Scrotal
☐ ABI
☐ Duplex Study Arterial or Venous _____
☐ Other _____

CT SCAN (Prerequisite: Creatinine and BUN within 1 month)

☐ Chest
☐ Abdomen
☐ Pelvis
☐ KUB
☐ IVP
☐ Soft Tissue Neck
☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine
☐ Angiography _____
☐ Head/Brain
☐ Sinus
☐ Other _____

Labs to be completed at:
☐ Outside labs (DLS, Clinical Labs)
☐ InSight Imaging

☐ Per Radiologist ☐ Without Contrast ☐ With Contrast ☐ With & Without

PET/CT SCAN

☐ Breast
☐ Cervix
☐ Colon (rectum, anus)
☐ Esophageal
☐ Head/Neck
☐ Lung Cancer
☐ Lymphoma
☐ Melanoma
☐ Neuroendocrine
☐ PSMA (Prostate)
☐ Other _____

REASON FOR EXAM
☐ Diagnosis
☐ Initial Staging
☐ Re-Staging

ORDERING PHYSICIAN

Name: _____

Signature: _____

Date: _____

DIAGNOSIS AND ICD CODE

_____

Copy To: _____