HALE PAWA'A

PHONE: (808) 591-1504
FAX: (808) 591-1506
1401 S. BERETANIA ST. #107
HONOLULU, HI 96814

PET/CT • DIAGNOSTIC CT APPOINTMENT

DATE: _____ ○ PATIENT CLAUSTROPHOBIC? PATIENT FOLLOW-UP

TIME: _____ PRIOR IMAGING: _____

PATIENT INFO AND INSURANCE

LAST: _____ FIRST: _____ ○ MALE ○ FEMALE

DOB: _____ HEIGHT/WEIGHT: _____ PHONE: _____

INSURANCE CARRIER: _____ AUTH #: _____

DIAGNOSIS / REASON (PLEASE SELECT ONLY ONE DIAGNOSIS AND ONE REASON)

DIAGNOSIS	REASON		
○ BREAST		○ STAGING	○ RESTAGING
○ COLON (RECTUM, ANUS)	○ FOR DIAGNOSIS	○ STAGING	○ RESTAGING
○ CERVICAL		○ STAGING	○ RESTAGING
○ ESOPHAGEAL	○ FOR DIAGNOSIS	○ STAGING	○ RESTAGING
○ HEAD/NECK (LIP, ORAL CAVITY, PHARYNX, NASAL CAVITY, EAR, SINUSES, LARYNX)	○ FOR DIAGNOSIS	○ STAGING	○ RESTAGING
○ LUNG CANCER	○ FOR DIAGNOSIS	○ STAGING	○ RESTAGING
○ LUNG ABNORMALITIES EVALUATION (SPN, LUNG NODULES)			
○ LYMPHOMA	○ FOR DIAGNOSIS	○ STAGING	○ RESTAGING
○ MELANOMA	○ FOR DIAGNOSIS	○ STAGING	○ RESTAGING
○ THYROID		○ STAGING	○ RESTAGING
○ DIFFERENTIATE BETWEEN FTD AND ALZHEIMER'S	○ FOR DIAGNOSIS		
○ DOTATATE		○ STAGING	○ RESTAGING
○ PSMA		○ STAGING	○ RESTAGING
○ OTHER NOT LISTED (ICD-10) _____	○ FOR DIAGNOSIS	○ STAGING	○ RESTAGING

DIAGNOSTIC CT REQUEST *(DIAGNOSTIC CT IS A SEPARATE STUDY FROM PET/CT AND IS REPORTED SEPARATELY)

○ HEAD / BRAIN
○ NECK
○ CHEST
○ ABDOMEN
○ PELVIS
○ OTHER (SPECIFY) _____

ADDITIONAL NOTES: _____ _____ _____

CONTRAST
○ YES
○ NO
○ PER RADIOLOGIST

WITH THIS FORM PLEASE INCLUDE THE FOLLOWING:

- DEMOGRAPHICS
- INSURANCE INFORMATION
- CLINICAL NOTES
- MOST RECENT IMAGING PERTAINING TO DIAGNOSIS
- ANY SURGICAL PATHOLOGY IF AVAILABLE

REQUESTING PROVIDER _____ PHONE: _____

CC TO: _____ PHONE: _____

PROVIDER SIGNATURE: _____ DATE: _____