Seattle Children's®
HOSPITAL • RESEARCH • FOUNDATION

PET Exam Request Form

Fax to **(206) 985-3128**
Scheduling Telephone **(206) 987-2089**

Today's date:	**MRN:**	
Last Name:	**First:**	**M.I.:**
Date of Birth:	☐ **Male** ☐ **Female**	
Parent/Guardian Name:		
Best Contact Phone: ( )	**Interpreter Needed** ☐ **Language:**	

☐ Please check if a CD of radiology images is to be sent with the patient

Exam Requested:

PET with Non Diagnostic CT

☐ Whole Body ☐ Brain ☐ Limited Area

*Non-contrast CT portion of PET-CT exam is for image calibration and is not a diagnostic CT (no IV contrast).
* No separate CT report
* For a diagnostic CT exam, please select box to right.

PET with Diagnostic CT

Body Part:

☐Head ☐ Neck ☐Chest
☐Abdomen ☐ Pelvis ☐Other: _____

Contrast:

☐ With contrast ☐ Without contrast
- Diagnostic CT includes a separate CT report

ICD9 (required): Code_____ Description _____

☐ Anesthesia needed ☐ Labs:

Please consider when ordering exams for female patients 11 years and older that radiation can be harmful to the patient and fetus. **Start date of last menstrual period:**

Relevant History of Present Illness/Complaint:

Incontinent?	**Diabetes?**	**Allergies?**	**G–CSF Therapy and Red Blood Cell Stimulating Drugs?**
☐ No ☐ Yes: If so, how controlled? ☐ Catheter ☐ Other:	☐ No ☐ Yes: How controlled? _____ ☐ Diet ☐ Insulin ☐ Oral Meds ☐ Fasting Glucose ☐ Metformin/Glucophage?	☐ NKDA ☐ Yes: What? _____ ☐ Previous allergy to iodine? ☐ Previous allergy to IV contrast?	When: _____ Type: _____ *Common G-CSF are Neupogen® and Neulasta®. *Common RBCS Drugs are Epogen® and Procrit®

Referring Physician *(include first and last name, please print):*	
Referring Physician signature:	
Best contact number for critical findings: ( )	**Fax #:** ( ) -
Please send an additional report to (Physician's first and last name):	**Fax #:** ( ) -

If child has acquired CT and/or MR images at another facility besides Children's Hospital, please forward the study to our Image Library, (206) 987-2731.