Phone:(360) 425-1003
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Nuclear Medicine Specialists:
H.H. Kim MD
W.J. Elton MD
H.G. Osman MD

Date Initiated: **Date of Exam:**

PATIENT INFORMATION: ☐ **Copy of Insurance Card**

Patient Name: ______________________________________ SSN: _____________________________

Address: ____

DOB: ___/___/___ Home phone: _____________ Work phone: ____________ Wt/Ht:____________

Insurance Company: __________________________ Precertification Phone Number: _________________

Address: ____

Policy Holder: _________________________ Group Number/ID Number:_________________________

EXAM REQUESTED: ☐**Oncology** ☐**Brain** ☐**Cardiac**

CLINICAL HISTORY:

Why is PET scan being requested: ____

Special Protocol Requested: ____

Is Patient Diabetic ☐ Yes ☐ No

If yes, how is it controlled? ☐ Oral Medication ☐ Insulin ☐ Other __________________________

Or, Is patient taking medication to control their blood sugar but are not diabetic? _______________________

Primary Diagnosis: ______________________________________ ICD-9 Code: _________________

Referring Physician: ____

Office Contact: ____________________ Office #: __________________ Fax #: _________________

☐ Recent history and physical information pertinent to request for PET Imaging
(Include chemotherapy information for oncology patients)

Date of last CT:	Date of last MRI:	Date of last PET:	Other Study_________ Date:
Where performed:	Where performed:	Where performed:	Where performed: