



Gulf Coast

MRI & Diagnostic PET/CT Scanning

Pasadena

5233 Fairmont Pkwy., Suite A
Pasadena, Texas 77505
(281) 991-1MRI (1674)
Fax (281) 991-3800

Patient's Name _____ DOB _____ Date _____

Phone: Home _____ Cell _____ Work _____

Referring Physician _____ Ph. # _____ Fax # _____

Physician's Address _____

****Please fax clinical information (PET/CT/X-ray, history and physical, lab, etc).****

DATE OF APPOINTMENT _____

Test(s) Requested _____

Insurance _____ Authorization # _____

- | | |
|--|---|
| <input type="checkbox"/> Standard Body (eyes to thighs protocol) | <input type="checkbox"/> Brain (Primary Brain Tumor Protocol) |
| <input type="checkbox"/> Body with Head | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Whole Body | |

- The patient is having or may have radiation therapy treatment.
- The patient has previously received a PET scan.

Reason for Scan:

Diagnosis _____

Staging (pre-treatment) of _____

Restaging (post-treatment) of _____

Treatment Response to _____

Special Instructions _____

- Schedule Deliver Film Phone Report STAT Report

-----Please Bring this form and your insurance information with you-----