

**H.O.P.E. IMAGING PET
Positron Emission Tomography**

Patient Requisition

Patient Information

Patient Name: _____ Primary Insurance _____
Patient Home Phone: _____ Primary Insurance Phone _____
Patient Work Phone: _____ Secondary Insurance _____
Patient Address: _____ Secondary Insurance Phone _____
City/State/Zip: _____ Physician Name _____
DOB: _____ Age _____ Sex _____ Physician Phone _____
SSN: _____ Physician Fax: _____

*****All Non-Medicare patients need precertification from their insurance company*****

Physician specialty:

___ Oncology ___ Pulmonary ___ Cardiology ___ Family Practice ___ Internal Medicine ___ Other ___

Physician's Signature _____ Date _____

Diagnosis: _____ ICD-9 _____

Films/reports for all studies previously performed for patient's condition must be included. If not available At time of scan, the interpretation/report may be delayed.

Please fax a copy of the above reports, with this requisition to (909)478-9193.