



Cardiac PET/CT Referral Form

6 Tsienneto Road, Suite 100LL. Derry, NH. 03038

Scheduling: 603.537.1363 | Fax: 603.537.3046 | Tax ID: 651188324 | NPI: 1891834545

PATIENT INFORMATION

■ Patient Name

■ Date of Birth

■ Height

■ Weight

■ Patient Address

■ Patient Telephone #

■ Patient Mobile #

Primary Insurance

Subscribers Insurance ID#

Secondary Insurance

Insurance Prior Authorization #

■ Referring Provider

Phone number

Exam Requested:

Reasons for Test (Check all that apply):

Stress Myocardial Perfusion PET (Rubidium) **CPT Code 78431**

Chest Pain

CAD Risk Stratification

Coronary Artery Disease

Shortness of Breath

LV Function/Dysfunction

Post MI Evaluation

Abnormal ECG

Post CABG Evaluation

Abnormal Treadmill Test

Other: _____ Post PTCA Evaluation

SIGNS AND SYMPTOMS (REQUIRED)

Clinical History: _____

Clinical Information: _____

Prior MI / PCI / CABG Diabetes

Pacemaker / ICD

Asthma / COPD

Cardiomyopathy

Left Bundle Branch Block

Authorized Treating Provider's Signature

NPI#

Date

Please FAX this form (and recent office notes, radiology reports and pathology reports) to the Scheduling Department once patient's examination has been scheduled.