

HEALTH VILLAGE IMAGING
PET SCAN PROTOCOL

PATIENT
NAME: _____ DOB: _____

Height: _____ Weight: _____

Primary Diagnosis (Reason for visit): _____

Exam Date: _____ Exam Time: _____

Diabetic: _____ If yes, Typical morning Glucose value: _____

Recent CT? _____ When: _____ Where: _____

Recent MRI? _____ When: _____ Where: _____

Previous PET SCAN? _____ Any chance of pregnancy? _____

Was patient instructed to bring any outside films? _____

Chemo Therapy? _____ Date: _____ Radiation Therapy? _____ Date: _____

Any Surgery in the area to be scanned? _____

Referring Doctor: _____

Primary Physician: _____

TECHNICIAN

_____ PET/CT TUMOR IMAGING. LIMITED CHEST, HEAD/NECK

_____ PET/CT TUMOR IMAGING. BASE TO MID THIGH

_____ PET/CT TUMOR IMAGING. WHOLE BODY

_____ BRAIN IMAGING. METABOLIC EVALUATION

_____ BRAIN IMAGING. PERFUSION EVALUATION

_____ MYOCARDIAL IMAGING. METABOLIC EVALUATION

_____ MYOCARDIAL IMAGING. PERFUSION, SINGLE STUDY AT REST OR STRESS

_____ MYOCARDIAL IMAGING. PERFUSION, MULTIPLE STUDIES REST AND/OR STRESS