NORTHPOINT

PET/CT

12606 Greenville Avenue, Suite 185 | Dallas, TX 75243
Phone: 469.364.7880

PET Scan Preparations:

• Avoid eating or drinking anything except water for 6 hours before your scan (including candy, mints, gum or coffee). Try to drink 6-8, 8-oz. glasses of water before your appointment.
• Avoid strenuous exercise the night before, and the day of your exam.
• Dress comfortable in loose clothing (clothing without metal snaps or buttons is best).
• Inform your doctor if you are diabetic, pregnant or a nursing mother.
• Take prescribed medications as usual.
• Arrive 10-15 minutes before your appointment time.
• If you are diabetic, eat a light low-carbohydrate meal 4 hours prior to your scan and then take your insulin or oral medication. Your blood sugar level should be less than 150 mg/dl when you arrive for your scan.

PET Scan Procedure:

• For the scan you will receive a small amount of radioactive glucose (blood sugar).
• You will rest quietly in a comfortable chair for approximately 60 minutes, while the glucose is distributed throughout your body.
• Then you will lie on a table that passes slowly through the scanner. The scanner resembles a CT scanner, but has a larger opening.
•The scan takes approximately 20 minutes.
• Once the PET scan is complete you will be able to leave.

NORTHPOINT
PET/CT

12606 Greenville Avenue, Suite 185 | Dallas, TX 75243
Phone: 469.364.7880

REQUEST FOR STUDY

Date:_____ Time:_____

Patient Information

Patient's Name:_____DOB:_____Ht:_____Wt:_____
Diabetic:____Yes____No Claustrophobic:____Yes____No Pregnant:____Yes____No
Allergies:_____
Has patient been on antibiotics or had surgery in the past six months? ____Yes____No
If yes, explain:_____

Please fax a copy of front & back of patient's insurance card(s).

PET/CT Scan:
____**Standard Body** (eyes to thighs protocol) ____**Brain** (brain protocol)
____**Whole Body** for Melanoma (head to toe protocol) ____**Alzheimer's** Disease
____**Body with head** for known or suspected brain mets

Reason for Study:

____Initial ____Restaging Other _____

____Treatment Response to _____ ____Diagnosis of _____

Diagnosis:_____IDC 9 Code:_____

Complete this box only for suspected Alzheimer's Disease & Frontotemporal Dementia.

- Date of onset of symptoms — Date: _____
- Diagnosis of clinical syndrome (e.g. normal aging, mild cognitive impairment or MCI: mild, moderate or severe dementia) — Date: _____ Examiner's name:_____
- Mini mental status exam (MMSE) or similar test score — Score: _____ Date: _____
- Presumptive cause (possible, probable, uncertain AD) — _____
- Any neuropsychological testing performed — In patient chart: Yes _____ No _____ Tests: _____
- Results of any structural imaging (MRI or CT) performed MRI _____ CT ____ Positive____ Negative __
- Relevant laboratory tests (B12, thyroid hormone) — In patient chart: Yes ___ No ___ Date:_____
- Number and name of prescribed medications — In patient chart: Yes ___ No ___

Ordering Physician:_____Physician's Signature:_____