PET Facility log-in information (facility ID, password):_____

1. PATIENT INFORMATION

Date: _____/_____/_____ Social Security #: ___ ___ ___ — ___ ___ — ___ ___ ___ ___

Last name: _____ First name:_____

Date of Birth: _____/_____/_____ Patient's Zip Code: ___ ___ ___ ___ ___

Gender: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown

Race: ☐ Asian ☐ Black or African American ☐ White or Caucasian ☐ Other ☐ Unknown

2. REFERRING PHYSICIAN INFORMATION

UPIN #: _____ **or** NPI #:_____

Last name: _____ First name:_____

Office Telephone: (___) _____ Office Fax: (___) _____

3. HAS THE PRE-PET FORM BEEN COMPLETED? ☐ Yes ☐ No

(if Yes is checked the PET facility will not be E-mailed a Pre-PET form to complete)

4. DATE PATIENT SCHEDULED FOR PET SCAN?___/_____/_____

(Must be within 14 days of registration.)

5. NAME OF PERSON SUBMITTING THIS FORM

Last name: _____ First name:_____ Date: _____/_____/_____