Mobile Molecular Imaging

100 Memorial Hospital Dr.
Suite 1-E
Mobile, Al. 36608
(251)316-3868 Fax:(251)316-3583

Physician / Referral Order Form

Patient: _____ **DOB:** _____
Exam Date: _____
Physician: _____ **Phone Number:** _____
Primary Physician: _____ **Phone Number:** _____
Diagnosis: _____ **(ICD 9 Code)**_____

Is Patient Diabetic? Yes □ No □ Insulin ? Yes □ No □ Oral Meds? Yes □ No □

PET/CT Exams: DO NOT USE FOR CT EXAMS. SEE BOX BELOW

Brain
□ Metabolic Evaluation
□ Refractory Seizures
□ Pre-Op Evaluation

Breast
□ Staging/Restaging
□ Treatment Response (during treatment course)

Colorectal
□ Diagnostic
□ Initial Staging
□ Restaging

Esophageal
□ Diagnostic
□ Initial Staging
□ Restaging

Head / Neck
(Thyroid & CNS Excluded)
□ Diagnostic
□ Initial Staging
□ Restaging

Lung
□ Diagnostic >4cm diameter (non-small cell ca)
□ Initial Staging (non-small cell ca)
□ Restaging (non-small cell ca)
□ Single Pulmonary Nodule <4cm diameter

Lymphoma
□ Diagnostic
□ Initial staging
□ Restaging

Melanoma
□ Diagnostic
□ Initial staging
□ Restaging

Other
□ Tumor Metabolic Evaluation
Specify Organ :_____
_____

CT Exams Please Specify:
Recent Lab Work (**Pts 65 and older and ALL diabetics** – within last 6 months)
BUN _____ **CREAT.** _____ **Date** _____

□ **W/contrast** **or** □ **W/O contrast**

□ Head □ Neck □ Chest □ Abdomen □ Pelvis □ Angio □ Extremities
□ Other: _____

Ordering Physician Signature: _____

Please fax this order to (____) _____
In order to achieve maximum benefit from the examination, please include:

1. Pathology/Biopsy/Surgical Reports
2. Recent history/physical/Office Notes or Progress reports

revised 07/11/07crs