



# WELCOME TO PET Imaging

## LOCATIONS:

### FORT COLLINS

PET Imaging of Northern  
Colorado  
1915 Wilmington Drive, Suite 101  
Ft. Collins, CO 80528

Phone: 970.204.0202  
Fax: 970.204.0208

### TULSA

PET Imaging of Tulsa  
6711 South Yale Avenue, Suite  
104  
Tulsa, OK 74136

Phone: 918.523.7200  
Fax: 918.523.7201

### NORTHEAST DALLAS

PET Imaging of Dallas -  
Northeast  
1250 Northwest Highway R  
Garland, TX 75041

Phone: 972.279.5172  
Fax: 972.279.6948

### SUGAR LAND

PET Imaging of Sugar Land  
17320 W. Grand Parkway S.,  
Suite A  
Sugar Land, TX 77479

Phone: 832.595.2713  
Fax: 832.595.2714

### THE WOODLANDS

PET Imaging of The  
Woodlands: College Park Plaza  
3091 College Park Drive, Suite  
340  
The Woodlands, TX 77384

Phone: 936.271.4060  
Fax: 936.271.4063

Thank you for choosing to have your imaging studies performed at PET Imaging. We provide quality imaging services in each of our locations and our staff strives to provide each of our patients with the individualized care they deserve. It is this compassionate approach, combined with our state-of-the-art facilities, comfortable environment and commitment to utilizing the most advanced techniques available that help make PET Imaging a premiere diagnostic center. For your first visit, please fully complete and sign all forms included in your packet. You will need to present these forms to the front desk upon your arrival. If you are unable to complete these forms before your first appointment, please arrive 30 minutes early and we will assist you. If you need to reschedule or cancel your appointment, please call at least 24 hours before your scheduled visit.

## PET SCAN PREPARATION

Please bring the following items to your appointment:

- Current insurance card and Driver's license or photo ID
- Payment
- You will be expected to pay your estimated co-payment, co-insurance and/or deductible at the time of your appointment.
- Bring relevant studies and reports to your appointment
- Please arrive 15 minutes prior to your scheduled appointment. The injection is time-sensitive and it is important for you to be on time.

## CLOTHING

Wear warm comfortable clothing that has no metal. You will be asked to remove all metal objects including snaps, zippers, buckles and jewelry prior to your scan.

## PREPARING FOR YOUR APPOINTMENT

A patient care coordinator will contact you prior to your appointment to discuss detailed preparation instructions and any prescription medications you may be taking. If you are diabetic, please call our office for special instructions.

- We have a television in the patient room. You may want to bring a book or music.
- If you are pregnant, maybe pregnant, or are breastfeeding, contact the PET Imaging office where you are scheduled.
- If you are claustrophobic, please obtain the proper medication from your physician and bring it to the appointment with you. Do not take the medication until the technologist instructs you. If you require medication for claustrophobia, you will need someone to drive you home.
- We do not provide or administer oxygen. If you are on oxygen, please bring enough to last for the two hour procedure plus the drive time to and from our center.
- Your appointment could take approximately 2 hours. The procedure will not affect your ability to drive.
- If you are unable to keep your scheduled appointment time, please call our office at least 24 hours in advance to avoid a \$150 missed appointment fee. The missed appointment fee is not covered by insurance. If you fail to provide the required notice, the center may charge you a \$150 fee.

## RESULTS

The images generated by the PET/CT scan combined with a written report from an interpreting physician will be communicated to your physician within 48 hours of your scan. Your physician will share your results with you.

Our website is [www.petimaging.us](http://www.petimaging.us). We look forward to seeing you and please do not hesitate to call if you have any additional questions or concerns.



# PATIENT INFORMATION

**PLEASE PRINT CLEARLY**

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female  Transgender:  M to F  F to M

SSN: \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Secondary Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_ May we email you?  Yes  No

Preferred Language: \_\_\_\_\_

Ethnicity/Race:  White  Hispanic/Latino  Black/African American  Native American

Asian/Pacific Islander  Other

Occupation: \_\_\_\_\_

Employed/Self Employed  Unemployed  Retired  Disabled

Name of Employer: \_\_\_\_\_ Work Phone: ( . ) \_\_\_\_\_

Relationship Status:  Married  Single  Widowed  Divorced  Other

Living situation:  Lives Alone  Lives with Family  Lives in Nursing Home

Winter Resident  Year Round Resident

Children:  Yes  No If yes, how many? \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Physician (if different): \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_ Phone #: \_\_\_\_\_

**Patient Initials:** \_\_\_\_\_



## PATIENT INFORMATION

### PLEASE PRINT CLEARLY

Patient Name: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: ( \_\_\_\_ ) \_\_\_\_\_

Durable Power of Attorney for Healthcare:  Yes  No \_\_\_\_\_

Please provide a copy for our records

Relationship: \_\_\_\_\_

Living Will for Healthcare:  Yes\*  No \*Please provide a copy for our records

**Primary** Insurance Carrier: \_\_\_\_\_

Name of primary policyholder: \_\_\_\_\_

Policyholder's Date of Birth: \_\_\_\_\_ Policyholder's SSN: \_\_\_\_\_

Policyholder's employer: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Secondary** Insurance Carrier: \_\_\_\_\_

Name of primary policyholder: \_\_\_\_\_

Policyholder's Date of Birth: \_\_\_\_\_ Policyholder's SSN: \_\_\_\_\_

Policyholder's employer: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

I certify that the information I have given today is to the best of my ability and as fully and accurately as possible. I will notify the front office/staff to any changes or additions at subsequent visits.

Signature of Patient or Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_



# AMYLOID HISTORY FORM

Reason for today's Amyloid PET scan: \_\_\_\_\_

Have you received Anti-Amyloid therapy, such as Leqembi or Kisunla?  Y  N

If you answered YES, when did you start treatment? \_\_\_\_\_

### COMPARISON BRAIN STUDIES: *(please obtain a copy for comparison to today's PET/CT scan)*

	Date	Facility
PET		
MRI		
CT		

### FILL OUT THE FOLLOWING IF IT APPLIES TO YOU:

History of stroke?      When:	Head injury?      When:
Have metal in the brain (from previous surgery, injury, etc.):	
On oxygen	Use a wheelchair or walker

### FEMALES:

Are you pregnant?       Y  N      ***If you are not sure, contact the technologist immediately!***

Are you breastfeeding?       Y  N      When was your last menstrual cycle?

Are you claustrophobic?       Y  N

If you are, has your doctor prescribed any medication for you to help relax you?       Y  N

If yes to above, do you have a driver to take you to and from the center after you take your relaxation medication?       Y  N

When is your follow-up appointment with your doctor? \_\_\_\_\_

List any other doctors you would like to send your Amyloid PET scan to: \_\_\_\_\_

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



# AMYLOID HISTORY FORM

**FOR TECHNOLOGIST USE ONLY: Initial each section when completed and print name below**

- Correct patient (verified by DOB and name): \_\_\_\_\_
- Correct procedure (check order): \_\_\_\_\_
- Correct radiopharmaceutical & dose (check syringe): \_\_\_\_\_

Print name of technologist:

\_\_\_\_\_

Patient Height: \_\_\_\_\_ ft \_\_\_\_ in

Patient Weight: \_\_\_\_\_ lbs.

Blood Glucose Level (for FDG only): \_\_\_\_\_ mg/dl

Injection Site: \_\_\_\_\_

Radiopharmaceutical Name:

\_\_\_\_\_

Dose assay and time (pre-injection): \_\_\_\_\_ mCi @ \_\_\_\_\_ : \_\_\_\_\_ AM/PM

Residual dose assay and time (post-injection): \_\_\_\_\_ mCi @ \_\_\_\_\_ : \_\_\_\_\_ AM/PM