

# PREP FOR CT SCAN

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## TENNESSEEOncology

a partner of  OneOncology™

Appt. Date: \_\_\_\_\_ Drink/Arrival Time: \_\_\_\_\_ Appt. Time: \_\_\_\_\_

### ❑ Tennessee Oncology PET Services

2018 Murphy Avenue, Suite 200 | Nashville, TN 37203  
Phone: 615.320.7387 | Fax: 615.327.3756

### ❑ Imaging Alliance-Nashville PET ❑ Tennessee PET Scan Center

1840 Medical Center Parkway, Seton Building, Suite 100 | Murfreesboro, TN 37129  
Phone: 615.890.5858 | Fax: 615.890.5670

### ❑ Franklin PET Center

4488 Carothers Parkway, Suite 110 | Franklin, TN 37067  
Phone: 615.721.0935 | Fax: 615.764.1924

### ❑ Lebanon PET Scan Center

103 Physicians Way, Suite 100 | Lebanon, TN 37090  
Phone: 615.453.7374 | Fax: 615.444.0492

### ▪ You may have plain water.

### ▪ Do not eat or drink for six (6) hours before your scan.

- Scans may be ordered with or without oral contrast.

If oral contrast is ordered with your scan, you will be arriving at your imaging center one (1) hour prior to your scan appointment to begin drinking contrast.

- Call 615.329.1599 to cancel or reschedule your appointment. Twenty-four (24) hour advance notice is **required** for any changes to your scheduled appointment time.

# PREP FOR P.E.T. SCAN

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## TENNESSEEOncology

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Appt. Date: \_\_\_\_\_ Drink/Arrival Time: \_\_\_\_\_ Appt. Time: \_\_\_\_\_

### ❑ Tennessee Oncology PET Services

2018 Murphy Avenue, Suite 200 | Nashville, TN 37203  
Phone: 615.320.7387 | Fax: 615.327.3756

### ❑ Imaging Alliance-Nashville PET Lions Head Village

52 White Bridge Road | Nashville, TN 37205  
Phone: 615.354.1255 | Fax: 615.354.9806

### ❑ Tennessee PET Scan Center

1840 Medical Center Parkway, Seton Building, Suite 100 | Murfreesboro, TN 37129  
Phone: 615.890.5858 | Fax: 615.890.5670

### ❑ Franklin PET Center

4488 Carothers Parkway, Suite 110 | Franklin, TN 37067  
Phone: 615.721.0935 | Fax: 615.764.1924

### ❑ Lebanon PET Scan Center

103 Physicians Way, Suite 100 | Lebanon, TN 37090  
Phone: 615.453.7374 | Fax: 615.444.0492

#### ▪ You may have plain water.

#### ▪ Do not eat or drink for six (6) hours before your scan.

- Eat a light, low carb meal as the last meal before your six (6) hour prep for the scan.
  - Do not have candy, gum or cough drops for six (6) hours prior to your scan.
  - Do not take any liquid medications before your scan. Any regular medications – pills, tablets, capsules – can be taken with water if tolerated on an empty stomach.
    - **Do not** take oral diabetes medication for six (6) hours before your scan. Give any insulin injections at least four (4) hours **before** your scan.
  - Avoid strenuous exercise, including rehab activities, for 24 hours before your scan.
  - Scans may be ordered with or without oral contrast. If oral contrast is ordered with your scan, you will be arriving at your imaging center one (1) hour prior to your scan appointment to begin drinking contrast.
- Call 615.329.1599 to cancel or reschedule your appointment. Twenty-four (24) hour advance notice is **required** for any changes to your scheduled appointment time.

# P.E.T. / CT ORDER FORM

## TENNESSEEOncology

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Tennessee PET Scan Center

Phone: 615.890.5858

Fax: 615.890.5670

Tennessee Oncology PET Services

Phone: 615.320.7387

Fax: 615.327.3756

Imaging Alliance-Nashville PET

Phone: 615.354.1255

Fax: 615.354.9806

Lebanon PET Scan Center

Phone: 615.453.7374

Fax: 615.444.0492

**CENTRAL SCHEDULING: 615.329.1599**

Appt. Date: \_\_\_\_\_ Drink/Arrival Time: \_\_\_\_\_ Appt. Time: \_\_\_\_\_

Auth # \_\_\_\_\_

### PET ORDER

STAT REPORT

Standard PET Scan (Skull base to mid thigh, CPT 78815)

Brain PET Scan, CPT 78608

Whole Body PET Scan (for Initial Staging Melanoma Only, CPT 78816)

Other, Specify \_\_\_\_\_

### CT ORDER

STAT REPORT

(IV CONTRAST WILL BE GIVEN WHERE APPROPRIATE UNLESS SPECIFIED OTHERWISE)

Chest

Head

Abdomen (diaphragm to iliac crest)

Orbits

Pelvis (iliac crest to pubis)

Sinus

Neck

Extremity, specify \_\_\_\_\_

Other, specify \_\_\_\_\_

### PATIENT DEMOGRAPHICS

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Social Security No: \_\_\_\_\_ Emergency Contact Name: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Signature: \_\_\_\_\_  
(Print Name) (NO STAMPS PLEASE)

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### CLINICAL INFORMATION

ICD-10 Code: \_\_\_\_\_ UNSPECIFIED CODES CAN NOT BE ACCEPTED

Primary Diagnosis: \_\_\_\_\_

ICD-10 Code: \_\_\_\_\_ UNSPECIFIED CODES CAN NOT BE ACCEPTED

Secondary Diagnosis: \_\_\_\_\_

IV Contrast Allergy: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Unknown

Location of Previous Scans: \_\_\_\_\_