ZANGMEISTER CANCER CENTER

A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

DIAGNOSTIC REFERRAL REQUEST

Please complete all fields and fax this to: **(614) 548-8340** or call **(614) 383-6475.**
Copies of this form may be downloaded from: **ZangCenter.com**

Patient Name: _____ **Date:** _____

Patient Address: _____
Street Address City State Zip

Home Phone: ( ) _____ **Other:** ( ) _____

DOB: _____ **SS#:** _____

Diagnosis/Reason for Testing: _____

Ordering Physician: _____ **Staff Contact:** _____

Phone: ( ) _____ **Fax:** ( ) _____

Primary Insurance: _____ **Secondary:** _____

Authorization #: _____ **Valid Dates:** _____ **to** _____

Creatinine: _____ **Date:** _____
(Recent Creatinine within 30 days of exam date for contrast enhanced CT scans)

Comments: _____

_____

PET IMAGING

____ PSMA Pylarify
____ Tumor Imaging Skull to Thigh
____ PET/Bone
____ Whole Body

DIAGNOSTIC PET/CT

(includes a diagnostic CT with or without contrast)

____ Diagnostic PET/CT Skull to Thigh
____ Diagnostic PET/CT Whole Body

X-RAY

____ Chest PA/LAT
____ Abdomen
____ Spine *Specify:* ○ *Cervical* ○ *Thoracic* ○ *Lumbar*
____ Shoulder *Specify:* ☐ *L* ☐ *R*
____ Hip *Specify:* ☐ *L* ☐ *R*
____ Ankle *Specify:* ☐ *L* ☐ *R*
____ Foot *Specify:* ☐ *L* ☐ *R*
____ Metastic Survey
____ Other *Specify:* _____

BONE MINERAL DENSITY

____ DEXA (includes hips & lumbar)

CT ☐ *With Contrast* ☐ *Without Contrast*

____ Chest Angiogram
____ Chest
____ Abdomen
____ Pelvis
____ Head/Brain
____ Sinus
____ Orbits
____ Neck - soft tissue
____ Thoracic
____ Lumbar
____ Lung Screen
____ High Res Chest
____ Upper Extremity *Specify:* _____
____ Lower Extremity *Specify:* _____
____ Other *Specify:* _____

NUCLEAR MEDICINE

____ Bone Scan ____ Octreoscan
____ Liver Scan ____ MUGA (Multi-Gated Acquisition - Cardiac EF)

Physician Signature: _____ **Date:** _____