DT18123

Children's℠ Healthcare of Atlanta

PET/CT

☐ **Egleston**
1405 Clifton Road
Atlanta, GA 30322
404-785-6078
FAX: 404-785-9082

ALL AREAS BELOW IN BOLD ARE REQUIRED

Patient's FULL LEGAL Name	**Date of Birth**	**Best Phone Number**
Address	**City, State**	**ZIP**
Insurance/Medicaid Plan	**Policy & Group#**	
Authorization# *(Please also fax a copy of insurance card, front and back, with this order)*	Guarantor's Email	
Reason For Exam ***(Signs, Symptoms, Chief Complaint)***		
Ordering Physician's Printed Name	**Practice Name**	
Ordering Physician's Signature	**Office Contact**	
Date/Time Signed	**Backline Phone**	**Fax**
PCP Name (if different):	**PCP Fax**	

SEDATION QUESTIONNAIRE

Developmental Delay? ❍ No ❍ Yes
Does this child require General Anesthesia? ❍ No ❍ Yes
History of apnea or obstructive breathing (e.g. snoring)? ❍ No ❍ Yes
Previous complication with sedation? ❍ No ❍ Yes

PET

❑ PET CT Whole Body (head to toes)
❑ PET CT Brain

CT

❍ **Contrast at Radiologist's Discretion**
❍ **Without Contrast** ❍ **With Contrast** ❍ **Without & With Contrast**

❑ Head
❑ Neck
❑ Chest
❑ Abdomen
❑ Abdomen/Pelvis
❑ Pelvis
❑ Other _____

Special Instructions
❑ Send CD with patient ❑ Send Film with patient

Date / Time Req: _____
Confirmed Appt: _____
Foster Child: ❑ Yes
Contact: _____

Order Comments / Other

Visit choa.org/radiology for a list of CPT codes, ACR ordering guidelines, or to request/print additional forms.