



DT18123



Children's<sup>SM</sup>

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**

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

**SEDATION QUESTIONNAIRE**

Developmental Delay? <input type="radio"/> No <input type="radio"/> Yes	History of apnea or obstructive breathing (e.g. snoring)? <input type="radio"/> No <input type="radio"/> Yes
Does this child require General Anesthesia? <input type="radio"/> No <input type="radio"/> Yes	Previous complication with sedation? <input type="radio"/> No <input type="radio"/> 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  Abdomen  Other \_\_\_\_\_  
 Neck  Abdomen/Pelvis  
 Chest  Pelvis

<b>Special Instructions</b> <input type="checkbox"/> Send CD with patient <input type="checkbox"/> Send Film with patient  Date / Time Req: _____ Confirmed Appt: _____ Foster Child: <input type="checkbox"/> Yes Contact: _____	<b>Order Comments / Other</b>   
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Visit [choa.org/radiology](http://choa.org/radiology) for a list of CPT codes, ACR ordering guidelines, or to request/print additional forms.