



Center for Imaging and Research of America

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**MOLECULAR IMAGING**

**CARDIAC PET/CT**

Myocardial PET/CT (78431)  Cardiac PET/CT Viability (78433)

With CFR (78434)  Sarcoidosis PET/CT

With Calcium Score (75571)

**ONCOLOGY PET/CT**

FDG PET/CT

Whole Body (78816)

Skull Base to mid thigh (78815)

PSMA PET/CT

**BRAIN PET/CT**

FDG Brain PET/CT (78608)

Amyloid Brain PET/CT

**GENERAL NUCLEAR MEDICINE (SPECT/CT) (\*)**

MUGA  Thyroid Uptake and Scan  Pipida Scan (Hepatobiliary)  Captopril renal scan

Bone Scan  Thyroid Imaging Only  Gastroesophageal reflux study  Indium Scan

Renal Scan  Thyroid Carcinoma Metastasis  Gastric emptying study  PYP Scan (cardiac Amyloidosis)

Myocardial Stress Test  Parathyroid Imaging  Bone Scan; Three phase study

Hepatobiliary Scan  Liver and Spleen  Brain Imaging tomo SPECT

Stress Test Plain (933015)

**CT SCAN**

WITHOUT CONTRAST  WITH CONTRAST (\*)  WITH OR WITHOUTOUT CONTRAST (\*)  CT ANGIOGRAM (\*)

I.A.C Plain  TMJ  CT Brain  Head

Spine Cervical  Foot  CT Chest  Neck

Lower Extremity Plain  Ankle  CT Abdomen  Pelvis W/O & W/Dye

Upper Extremity Plain  Knee  CT Pelvis  Upper Extremity W/O & W/Dye

Maxillofacial Plain  Hand  CT Lumbar Spine  Lower Extremity W/O & W/Dye

Neck Soft Tissue Plain  Wrist  CT Thoracic Spine  Abdomen W/O & W/Dye

Plain Orbits Plain  Elbow  CT Thorax  Coronary

Renal Stones  Shoulder  CT Cervical Spine

Facial Bone  CT Brain  CT for Localization

Calcium Score  CT ABD Aorta & Bilat iliofemoral Low Ext Runoff

Low Dose CT-Lung Cancer Screening

Other: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Home Tel: \_\_\_\_\_  
Other Phone: \_\_\_\_\_ Patient Address: \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Carrier: \_\_\_\_\_ Tel. No: \_\_\_\_\_ Group No: \_\_\_\_\_  
Policy No: \_\_\_\_\_ ID No: \_\_\_\_\_ Claim No: \_\_\_\_\_ Authorization No: \_\_\_\_\_

**PHYSICIAN INFORMATION**

Referring Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Office Contact: \_\_\_\_\_ Ext: \_\_\_\_\_ Fax Results to: \_\_\_\_\_ Fax No: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**APPOINTMENT INFORMATION**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Courtesy Transportation Necessary:  YES  NO

If (YES), please provide address or location for pick up: \_\_\_\_\_

**Note: Services marked with an asterisk (\*) are performed only at select locations**