

Nuclear Medicine Order

147 North Brent Street, Ventura, CA

Mountain Tower, 1st Floor

Phone: 805-948-5026 Fax: 805-948-0433 Email: NucMed@mycmh.org



Patient's Name _____ Date of Birth _____

Phone(s) _____ Email _____

Insurance or Authorization Number _____

Diagnosis _____ Order Date _____

Referral Physician Signature _____ Phone _____

Please call for pre-study instructions and bring this form with you to your appointment.
If you are unable to keep your appointment, please call or email 24 hours in advance

GENERAL NUCLEAR MEDICINE STUDIES

Appointment Date _____ Appointment Time _____ Return Time _____

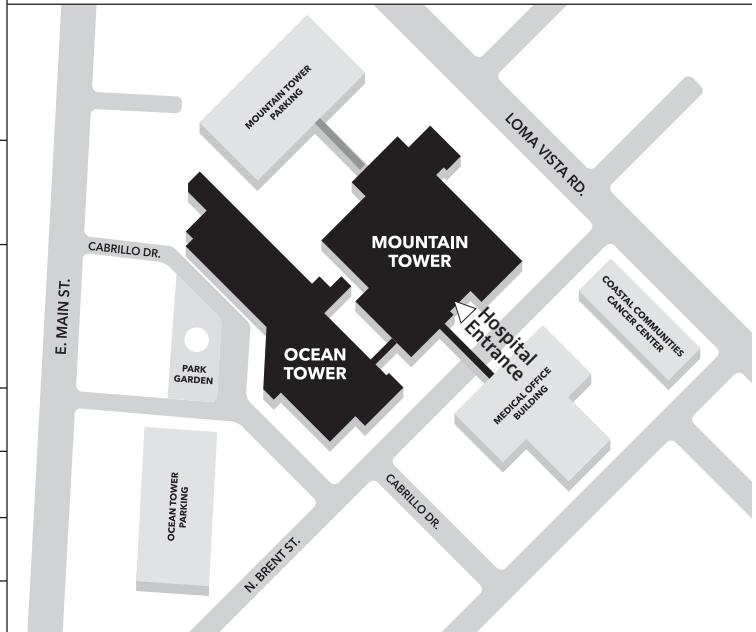
 Bone Scan Whole body 3-phase Limited **Brain** Cisternogram CSF-Leak DaTscan
 VP Shunt Study **Cardiac** Stress Test

(4 hour fast, no caffeine 12 hours prior, bring medication list)

 Pharmacologic Exercise

Height _____ Weight _____

Allergies _____

 Cardiac Amyloid (PYP) MUGA **Gastrointestinal** Hepatobiliary (HIDA) w/ Pharm (4 hour fast) Bile leak Gastric empty (4 hour scan) GI Bleed Hemangioma HEPATIQ Liver/Spleen **Infection/Tumor** White Blood Cell (WBC) Gallium **Lymphoscintigraphy** Breast w/ Imaging L R Breast w/o Imaging Lymphedema Melanoma, site: _____ **Meckel's** **MIBG** **Octreoscan** **Parathyroid** **Pulmonary** Lung VQ Quantification R to L Vascular Shunt **Renal** Function & Flow Lasix Function & Flow Captopril **Thyroid***Diagnostic* I-123 Uptake and Scan I-131 Whole Body Scan*Treatment* I-131 Cancer I-131 Hyperthyroid **Yttrium 90 Theraspheres (consultation needed)** **Other** _____

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