

## LU-177 PSMA Treatment Patient Referral Form

Please return by fax to (512) 451.3554.

Patient name: _____	Patient preferred phone: (_____) _____  Patient email: _____
Date of birth: _____	Height/weight: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female
Referring physician: _____	Referring physician phone/fax:  Ph: _____ Fax: _____  Point of contact at referring physician's office:  Name: _____ Phone: _____
Patient insurance name & authorization number:  Insurance: _____ Auth #: _____	
Reason for therapy: <input type="checkbox"/> Metastatic castration-resistant prostate cancer <input type="checkbox"/> Other _____  Please include the following: <input type="checkbox"/> Copies of all insurance cards <input type="checkbox"/> Current labs <input type="checkbox"/> Medical history and clinical notes <input type="checkbox"/> Copies of (non-ARA) PET scan reports  Physician update preference: <input type="checkbox"/> Please have the treating radiologist call the referring physician with updates.  Preferred physician phone: _____	
Relevant notes on patient case:  _____ _____ _____ _____ _____ _____ _____ _____ _____	
Ordering physician signature (required): _____ Date: _____	

The molecular radiology team is here to help you. Please contact Alex DiFonzo at (512) 519-3456, ex. 2351 or [theranostics@ausrad.com](mailto:theranostics@ausrad.com) with any questions or issues regarding your patient and their treatment.