

SSTR-targeted Therapy 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"/> Gastroenteropancreatic neuroendocrine tumor(s) <input type="checkbox"/> Other _____ Date of last somatostatin analog treatment: _____ Please include the following: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Copies of all insurance cards <input type="checkbox"/> Relevant pathology (with Ki-67 index) </div> <div> <input type="checkbox"/> Current labs <input type="checkbox"/> Copies of (non-ARA) PET scan reports </div> <div> <input type="checkbox"/> Medical history and clinical notes </div> </div> 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: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	
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 with any questions or issues regarding your patient and their treatment.