Center of Molecular Radiotherapy

Department of
Nuclear Medicine

Director: Prof. Dr. med. Samer Ezziddin

Universitätsklinikum des Saarlandes

Request Form for Nuclear Medicine Examination

Please send by fax to 06841 – 16 1724666

Requested examination: _____ (bone scan, renal function scintigraphy, ect.)

Patient data:

Last name: _____

First name: _____

Date of birth: _____

Street: _____

ZIP-Code/City: _____

Tel.-No.(for scheduling) _____

☐in-patient ☐out-patient

Infectious patient: ☐Yes ☐No Pathogen: _____

Health insurance status:

☐legal ☐private

☐direct payer

☐TRICARE:

☐ active duty ☐ retiree

☐ family member

☐ claim development worksheet

☐ tricare authorization form

Weight: _____ kg

Diagnosis/clinical information/medical questions:

Relevant previous examinations:

Requesting doctor: _____

Tel.-No.: _____

Clinic/Dept.: _____

Stamp

SUBMIT