ARA Theranostics
EXPERTS IN MOLECULAR IMAGING & THERAPY

PRRT (Lutathera) Patient Referral Form

Please return by fax to (512) 836-8869

Patient name:	Patient preferred phone: (_____) _____ Patient email: _____
Date of birth:	Height/weight: _____ ☐ Male ☐ 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: ☐ Gastroenteropancreatic neuroendocrine tumor(s) ☐ Other _____

Date of last somatostatin analog treatment: _____

Please include the following:

☐ Copies of all insurance cards ☐ Current labs ☐ Medical history and clinical notes

☐ Relevant pathology (with Ki-67 index) ☐ Copies of (non-ARA) PET scan reports

Physician update preference:

☐ 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 (512) 519-3456, ex. 2351 or theranostics@ausrad.com with any questions or issues regarding your patient and their treatment.