OSCEOLA
CANCER CENTER

«PracticeAddrCSZ» «PracticePhone»

Patient: «PatientFullName» **«CurrentDate»**
Account: «PatientNumber»

Your CT scan appointment has been scheduled at our facility on:

____ @ __________ __AM __ PM

PLEASE READ AND INITIAL ONLY THE HIGHLIGHTED AREAS

______ No food or drink at least 4 hours prior to CT scan.

_____ Drink contrast two (2) hours prior to test time. **DRINK BY: ________________**
(For Abdomen/Pelvis & Pelvis Only)

_____ Drink contrast one (1) hour prior to test time. **DRINK BY: ________________**
(For Abdomen Only)

_____ Medication may be taken with little water.

_____ Please be advise that you must bring with you, prior films and reports or your CT scan will be rescheduled.

_____ Your insurance may require an authorization or referral from you Primary Care Physician (PCP). It is your responsibility to contact your PCP's office to make sure they have faxed your authorization or referral to our facility. If not received by 12pm on the day prior to your appointment, your CT scan will be rescheduled.

_____ Dr. Havas is the Radiologist who will be reading your CT scan. You may receive a separate bill from his office. Should you have any questions regarding such bill, please contact his office directly at (352) 795-9729

_____ You have been given a lab requisition today. Lab work needs to be completed one (1) week prior to this appointment. If not, your CT scan will be rescheduled.

____
Patient Signature

____
Patient Name (please print)

Scheduler's Name: ____