

BOOKING HOTLINE 0207 535 1966

Request Form: PET and PET/CT

Please complete all sections of this request form
Signed forms may either be faxed to +44 (0)20 7935 7715 or posted to:
Alliance Medical Imaging Centre, 10-11 Bulstrode Place, London W1U 2HX

Patient details

Name:

Address

Postcode:

Tel: Mobile:

Email:

Date of birth:

Male / Female:

Start date of Last Menstrual Period (if applicable):

Patient arrival: Trolley Wheelchair Walking

Funding: NHS Self Funded Private Patient

Patient's insurance company:

Membership number:

Pre-authorisation number (if known):

Please note: Uninsured patients and patients without pre-authorisation are required to pay on the day of their appointment.

Referral information

Type of examination requested:

- PET/CT with CT scan for anatomical fusion only
 PET Only
 PET/CT PLUS Full Diagnostic CT
(Separate CT request form must also be completed)

Reason for referral:

Please indicate the site of primary disease
Or the area under consideration:

Relevant previous medical history

Details (including any surgery and current medication):

Chemotherapy

Radiotherapy

Type:

Cycle length:

Date of last treatment:

Please include copies of any recent X-Rays or scan reports

Safety check

Could the patient be pregnant? Yes No

Is the patient breast feeding? Yes No

Is the patient a high infection risk? Yes No

If yes, please specify:

Is the patient diabetic? Yes No

Is the diabetes controlled by: Diet Insulin Tablet

Does the patient have any allergies? Yes No

If yes, please specify:

Referring Clinician's details

IR(ME)R 2000 regulations require this form to be signed
by the referring Clinician.

Consultant name:

Signature:

Date:

Hospital (if applicable):

Address:

Tel:

Email:

Fax:

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