Alliance Medical

NHS

PET/CT Patient Request Form

All sections indicated with an asterisk MUST be completed. Incomplete referrals may experience delays in appointment allocation.

Please send completed request forms along with previous relevant imaging reports to:
Birmingham PET/CT Centre
Queen Elizabeth Medical Centre, Birmingham B15 2TH
Tel **0121 627 5811** Fax **0121 627 5815**
Email **birminghampet@nhs.net**

Patient details

* Name
* Address

* Postcode
* Date of Birth
* Gender
* NHS No
* Hospital PAS No
* Patient Tel no
Day Eve
Mobile
Email

* Patient category please tick

NHS O/P ☐ NHS I/P ☐ Private ☐ Self Funded ☐
Research ☐ Please state Research Trial:

* Mobility please tick

Walk ☐ Chair ☐ Bed ☐ Hospital Transport ☐
Special needs e.g. interpreter (language), disability, visually impaired, hard of hearing (please specify):

* Accession No
* Referring CCG Code
GP Name
GP Address
GP Postcode

Clinical information

* Diagnosis

* When is the scan required? Next available? Yes ☐
or Specific date DD / MM / YY
Next Appointment with Referrer / MDT DD / MM / YY

* Indicate site of primary disease or area under consideration

* Diagnostic Question?

Relevant medical history

Radiotherapy	Type & Area Treated	Start Treatment Date	Last Treatment Date	Next Treatment Date (if applicable)
Chemotherapy	Type	Start Treatment Date	Last Treatment Date	Next Treatment Date (if applicable)
Biopsies & Relevant Prior Surgery		Date	Type & Location on Body	Result
Recent Cross-sectional Imaging		Type	Hospital	Date

Additional Relevant Information *(current medication & known allergies)*

Does the patient have any history of venous access problems? Yes ☐ No ☐
Administration of FDG via central lines may only be performed with prior agreement from the ARSAC holder. In all other cases peripheral venous access must be obtainable.

Safety check

* Could the patient be pregnant? Yes ☐ No ☐
Is the patient breast-feeding? Yes ☐ No ☐
Date of last menstrual period DD / MM / YY
If the patient is diabetic: Diet ☐ Tablet ☐ Insulin ☐

Does the patient have contraindications to CT contrast? Yes ☐ No ☐
* Is the patient an infection risk? Yes ☐ No ☐
If yes, please specify (please see overleaf for infectious disease contraindications)

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* Patient Name	* Date of Birth

Referrers details (person completeing the form)

* Name

* Job Title

* Hospital NACS Code

* Address

* Bleep / Mobile / Ext Fax

Referrers Email

* Referrers Signature

GMC Code

Additional copy of report to be sent / faxed / emailed to: (specify)

Full Name and Address

Bleep / Mobile / Ext Fax

Email

Have you submitted previous imaging? Yes ☐ No ☐

Please Note: If previous imaging and reports have not been submitted then this may result in delays in appointment allocation and PET/CT reporting

* Referral Date DD / MM / YY

Specific clinical contraindications to PET/CT include: Pregnancy or suspected pregnancy

Clinical contraindications rendering the patient medically unfit to undergo the scan include:
Chest drains in situ, Influenza, Chickenpox (Varicella Zoster Virus), Measles (Rubella), Mumps, Clostridium Difficile (may only be scanned at static centres), Whooping cough (Bordetella pertussis), Active Shingles (Herpes Zoster), Diphtheria (Corynebacterium diphtheriae)

Additional physical and technical contraindications to PET/CT include:

Inability to cooperate with the scan process - For instance, inability to lie relatively still for 1-2 hours and to lie supine for 30-60 minutes

Blood Glucose Level - If the patient's blood glucose level is outside the ARSAC certificate holder's agreed limits. In patients with diabetes this must be adequately controlled prior to attendance for the PET/CT scan. Uncontrolled blood glucose levels may result in sub-optimal or undiagnostic image quality and therefore in these circumstances the patient's appointment may be cancelled and re-scheduled for an alternative date when diabetic control has been established

Chemotherapy/Radiotherapy - If the patient's appointment date is outside the ARSAC certificate holders agreed time limits

Patient weight above scanner limit - GE Discovery ST PET/CT scanner 180kg

Patient body habitus above scanner dimensions - Scanner Bore Diameter 70cm (distance from scanner bed to roof of scanner approximately 50cm). If it is uncertain if a patient's body habitus will prevent us from proceeding with the scan the patient may be invited to attend the scanner prior to their appointment date to undergo a trial run through the scanner gantry

ARSAC Process - ARSAC Licence Holder or Delegate to complete

ARSAC Authorisation (please indicate) ☐ Pre-referral to PMC ☐ Under delegation

* PET/CT protocol
☐ Half Body PET/CT (Orbits to Mid Thigh)
☐ Head & Neck (Vertex to Mid Thigh)
☐ 3D Brain
☐ Other:
☐ Total Body PET/CT (Vertex to Toes)
☐ Head & Neck Supplementary (Vertex to Lung Apices) + Modified Half Body PET/CT (Lung Apices to Mid Thigh)

* Clinical Indication & CRIS Coding (please tick one box from each table):

Lung	☐		Staging	JA	☐
Oesophagus	☐		Re-staging	JB	☐
Colorectal	☐		Recurrence	JC	☐
Lymphoma	☐		Residual Mass	JD	☐
Head & Neck (includes H&N unknown primary)	☐	Please state:	Follow Up (response to therapy)	JE	☐
Melanoma	☐		Characterisation	JF	☐
Unknown Primary (excludes H&N unknown primary)	☐		Pre-resection Metastases	JG	☐
Upper GI (includes Stomach, Small Bowel, Liver, Pancreas)	☐	Please state:	Find Unknown Primary	JH	☐
Sarcoma	☐		Elevated Tumour Markers	JI	☐
Breast	☐		Paraneoplastic Syndrome	JJ	☐
Urological (includes Renal, Adrenal, Bladder, Prostate, Testicle)	☐	Please state:	Other Oncology	JK	☐
Gynaecological (includes Ovary, Uterus, Cervix)	☐	Please state:	Non-Oncology: Neurology	JL	☐
Brain & Spinal Cord	☐	Please state:	Non-Oncology: Cardiac	JM	☐
Oncology : Other	☐	Please state:	Non-Oncology: Other	JN	☐
Non-Oncology: Neurology	☐				
Non-Oncology: Cardiac	☐				
Non-Oncology: Other (includes vasculitis, infection imaging)	☐	Please state:			

* ARSAC Authoriser Name: * ARSAC Authoriser Signature: * Date: DD / MM / YY