

# PET/CT Patient Request Form

Please refer to page 2 for the contraindications to PET/CT

Please complete all the sections on this page. Failure to do so may delay appointment being made.

<b>PATIENT DETAILS</b> <b>HOSPITAL NO:</b> Title:      First name:      Surname: Accession No: Address: Postcode:      Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Email: Tel no:      Mobile: Date of Birth:      Next of Kin: <hr/> <b>G.P. Details:</b> Title:      Surname: Surgery address:		Patient arrival:    Trolley <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walking <input type="checkbox"/> Funding:      NHS <input type="checkbox"/> Self Funded <input type="checkbox"/> Insured <input type="checkbox"/> Research patient:      Commercial <input type="checkbox"/> Non-commercial <input type="checkbox"/> REC Trial No: <input type="text" value="XX / XX / XXXX"/> Trial name: Patient's insurance company: Membership number: Pre-authorisation number (if known): Is an interpreter required?      Yes <input type="checkbox"/> No <input type="checkbox"/> Is transport required?      Yes <input type="checkbox"/> No <input type="checkbox"/>	
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**MEDICAL HISTORY**

Has the patient had any surgery in the last six weeks?  
 If yes, please list procedure and anatomical site:

	Chemotherapy	Radiotherapy
Type:		
Cycle length:		
Date of last treatment:		
Date of next treatment:		
MDT date:		
Breach date:		
Requested date for scan:		

**CLINICAL INDICATIONS**

**Reason for referral:** (including any surgery, current medication and correlative imaging):

2 week wait?      Yes       No   
 62 day target patient?      Yes       No   
 Last diagnostic PET/CT: Date      Body area:  
 Last diagnostic CT:    Date      Body area:  
 Last diagnostic MRI:    Date:      Body area:

PLEASE ENSURE YOU SEND A COPY OF THE LATEST CT/MRI REPORTS WITH THE REQUEST FORM

**SAFETY CHECK**

Could the patient be pregnant?      Yes       No   
 Is the patient breast feeding?      Yes       No   
 Is the patient claustrophobic?      Yes       No   
 Does the patient have mobility issues?      Yes       No   
 Is the patient part of a trial?      Yes       No   
 If yes, please specify:  
 Approximate Weight:

Is the patient known to carry a high risk infection ?      Yes       No   
 If yes, please specify:  
 Does the patient have any known allergies?      Yes       No   
 If yes, please specify:  
 Does the patient suffer from diabetes?      Yes       No   
 Is the diabetes controlled by:      Diet       Insulin       Tablet   
 Does the patient suffer from incontinence?      Yes       No

**REFERRING CLINICIAN DETAILS**

IR(ME)R2000 regulations require this form to be signed by the referring Consultant:  
 GMC Number:  
 Email:  
 Print Name:      Date:

Hospital:  
 Address:  
 Tel:      Fax:  
 Consultant Signature:

Patient Name	Date of Birth
<b>CLINICAL INDICATION CODING</b> (please tick one box from each table):	
Lung <input type="checkbox"/> Oesophagus <input type="checkbox"/> Colorectal <input type="checkbox"/> Lymphoma <input type="checkbox"/> Head & Neck (includes H&N unknown primary) <input type="checkbox"/> Please state: Melanoma <input type="checkbox"/> Unknown Primary (excludes H&N unknown primary) <input type="checkbox"/> Upper GI (includes Stomach, Small Bowel, Liver, Pancreas) <input type="checkbox"/> Please state: Sarcoma <input type="checkbox"/> Breast <input type="checkbox"/> Urological (includes Renal, Adrenal, Bladder, Prostate, Testicle) <input type="checkbox"/> Please state: Gynaecological (includes Ovary, Uterus, Cervix) <input type="checkbox"/> Please state: Brain & Spinal Cord <input type="checkbox"/> Please state: Oncology: Other <input type="checkbox"/> Please state: Non-Oncology: Neurology <input type="checkbox"/> Non-Oncology: Cardiac <input type="checkbox"/> Non-Oncology: Other (includes vasculitis, infection imaging) <input type="checkbox"/> Please state:	Staging JA <input type="checkbox"/> Re-staging JB <input type="checkbox"/> Recurrence JC <input type="checkbox"/> Residual Mass JD <input type="checkbox"/> Follow Up (response to therapy) JE <input type="checkbox"/> Characterisation JF <input type="checkbox"/> Pre-resection Metastases JG <input type="checkbox"/> Find Unknown Primary JH <input type="checkbox"/> Elevated Tumour Markers JI <input type="checkbox"/> Paraneoplastic Syndrome JJ <input type="checkbox"/> Other Oncology JK <input type="checkbox"/> Non-Oncology: Neurology JL <input type="checkbox"/> Non-Oncology: Cardiac JM <input type="checkbox"/> Non-Oncology: Other JN <input type="checkbox"/>

<b>ARSAC PROCESS</b> - ARSAC Certificate Holder or Delegate to complete	
ARSAC Authorisation (please indicate) <input type="checkbox"/> Pre-referral to PMC <input type="checkbox"/> Under delegation	
<b>Protocol required:</b> Vertex to toes PET/CT <input type="checkbox"/> Base of skull to proximal third of femur PET/CT <input type="checkbox"/> Lung Apices to proximal third of femur PET/CT <input type="checkbox"/> Symphysis pubis to toes PET/CT <input type="checkbox"/> Vertex to proximal third of femur PET/CT <input type="checkbox"/> Vertex to Lung Apices PET/CT <input type="checkbox"/> Brain PET/CT <input type="checkbox"/> Other (please specify) <input type="checkbox"/> Prostate - Dynamic PET/CT <input type="checkbox"/> Other - Dynamic PET/CT <input type="checkbox"/>	<b>Tracer required:</b> FDG <input type="checkbox"/> FEC <input type="checkbox"/> NaF <input type="checkbox"/> Amyloid <input type="checkbox"/> Other (please state) <input type="checkbox"/> Can patient be scanned in Radiotherapy Planning Position? Yes <input type="checkbox"/> No <input type="checkbox"/>  <b>Clinical authorisation by ARSAC certificate holder or delegate:</b> Print Name: Signature: Date:

<b>SPECIFIC CLINICAL CONTRAINDICATIONS TO PET/CT INCLUDE:</b> Pregnancy or suspected pregnancy <b>Clinical contraindications rendering the patient medically unfit to undergo the scan include:</b> 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) <b>Additional physical and technical contraindications to PET/CT include:</b> <b>Inability to cooperate with the scan process</b> - For instance, inability to lie relatively still for 1-2 hours and to lie supine for 30-60 minutes <b>Blood Glucose Level</b> - 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 <b>Chemotherapy/Radiotherapy</b> - If the patient's appointment date is outside the ARSAC certificate holders agreed time limits <b>Patient body habitus above scanner dimensions</b> - 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
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