



PET/CT SCAN REQUISITION

**Centre of Excellence for Functional Cancer Imaging
 Vancouver Centre**

Phone: (604)707-5951 Fax: (604)877-6245

Current Date: _____

Referring Physician: _____

Phone: _____

Fax: _____

Appointment Date: _____ Time: _____

Patient Notified on: _____ Notified by: _____

(for Dept use only)

Incomplete Referrals Will Be Returned

Patient Information

Important: Height _____ Weight _____ (kg / lb)

Name: _____ Preferred Name: _____

Surname First Middle

Date of Birth: D _____ M _____ Y _____ PHN: _____ Sex: Male / Female

Home Address: _____

Home Phone: () _____ Work: () _____ Mobile: () _____

Temporary Address: _____ Temporary Phone: () _____

Family Physician: _____ Phone: () _____

Patient mobility: ambulatory / wheelchair / stretcher

Diagnosis/Pertinent History

(include recent surgery, chemotherapy, radiotherapy):

If applicable, Clinical Trial Name: _____

Radiotracer Requested: _____

Contact Person: _____

Phone Number: _____

Specific Indication for PET/CT Request

Essential Information

Additional Information

Is patient aware of PET consent form? Y N

Note: All BCCA PET/CT scans are done under **Clinical Trials**

Does patient require an interpreter? Y N

Language: _____

Does patient have any drug allergies? Y N

Does patient have IV contrast allergies? Y N

Is patient diabetic? Y N

Is patient pregnant or breastfeeding? Y N

Does patient have claustrophobia? Y N

Can patient lie flat for 45 minutes? Y N

Barium study within the past week? Y N

CT scan within 3 months? Y N

Performed at: _____

MRI scan within 3 months? Y N

Performed at: _____

Nuclear Med scan within 3 months? Y N

Performed at: _____

Previous PET or PET/CT scan? Y N

Performed at: _____

Doctor's Signature: _____

MSP No: _____

Additional Copies of Report to: _____

Referring physician will be sent and asked to complete a brief post-scan questionnaire