FDG PET/CT SCAN REQUISITION

Molecular Imaging and Therapy Phone: 604-707-5951 Fax: 604-877-6245

INCOMPLETE REFERRALS WILL BE RETURNED - *Mandatory fields highlighted in red*

Current Date:

Referring Physician:

Phone: **Fax:**

MIT Department use only

Scan Date:_____Time: _____

Indication #:_____ 1A 1B 2 3

Details: _____

Routine H/N TB Brain ToH Arms: Up Down

Other: _____

Date: _____ PET Dr. Initial: _____

PATIENT INFORMATION

Last Name: First Name: Preferred Name:

CST Cerner MRN: PHN: ☐ Out of Province ☐ Self-pay

DOB: DD MON YYYY Gender: ☐ Out Patient ☐ In Patient Location:

Home Address: City: Postal Code:

Phone: Mobile: Weight: kg Height: cm

Family Physician: Phone:

REQUESTED EXAM DATE:

(If left blank, earliest date possible will be booked)

Priority: ☐Urgent ☐Routine ☐Timed

Special Instructions / Notes to Scheduler:

Diagnosis / Pertinent History:

PET/CT REQUEST *(Indication is required - select from drop down list)*

Adult Indications:

Pediatric Indications:

If OTHER, please specify. Request will be reviewed by the Molecular Imaging and Therapy Physician for approval.

If Clinical Trial requested:

Clinical Trial Name: Radiotracer: Contact: Phone:

IMAGING REQUIREMENTS

☐ RT Planning ☐ Flat RT Couch Top / Overlay ☐ H/N ☐ Shell Other:

ADDITIONAL INFORMATION

CT scan within 3 months?	Y ☐ N ☐	Possibility of pregnancy?	Y ☐ N ☐		
MRI scan within 3 months?	Y ☐ N ☐	Interpreter required?	Y ☐ N ☐	Language:	
NM scan within 3 months?	Y ☐ N ☐	Drug Allergies?	Y ☐ N ☐	Drug/Reaction:	
Previous PET or PET/CT scan?	Y ☐ N ☐	Claustrophobic?	Y ☐ N ☐		

Doctor's Signature: MSP No:

Additional Copies of Report to:

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CANADA V5Z 4E6

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