PET/CT SCAN REQUISITION - KELOWNA

Functional Imaging - PET/CT

Phone: 250-861-6456 Fax: 250-861-6459

Email: PET/CTKelownaBooking@bccancer.bc.ca

Current Date: Referral Location: Kelowna

Referring Physician: MSC Id:

Physician Phone: Fax:

CC Report to:

For department useonly

APPT Date: Time: PT Notified: Init:

☐ 1A ☐ 1B ☐ 2 ☐ 3 Date: Init.: Init.:

☐ R ☐ HN ☐ TB ☐ TOH Arms: ☐ U ☐ D ☐ Resp Gate

Other:

PATIENT INFORMATION

Legal Surname: Legal First: Preferred Name:

Agency ID PHN: ☐ Out of province ☐ Self-pay

DOB: DD MMM YYYY Sex: ☐ Out patient ☐ In patient Location:

Home Address: City: Postal Code: Phone: Mobile:

Weight: Height: Family Physician: Phone:

DIAGNOSIS/PERTINENT HISTORY

(Include recent surgery, chemotherapy, radiotherapy...)

PET/CT REQUEST

Adult Indications:

Pediatric Indications:

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

If Clinical Trial requested:

Clinical Trial Name: Radiotracer: Contact Person: Phone:

IMAGING REQUIREMENTS

RT Planning: ☐ Lung Board - Tbar ☐ H/N ☐ Shell ☐ 4D ☐ Other: ☐ IV Contrast *(complete section below)*

ADDITIONAL INFORMATION

CT scan within 3 months?

MRI scan within 3 months?

Nuclear Medicine scan within 3 months?

Previous PET or PET/CT scan?

Claustrophobic?

Possibility of Pregnancy?

Interpreter required? Language:

IV contrast or drug allergies? Drug/reaction:

For IV contrast procedure: eGFR (< 3 months) mL/min

Date:

Submit by Email

BC Cancer - Kelowna
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V1Y 5L3
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