

PET/CT REFERRAL FORM

# FAX REQUESTS TO: 01- 4284137

**St. James’s PET CT Centre, Hospital 1 Ground Floor.**

**Tel (353 1) 428 4947 Email –** **PetCT@stjames.ie**

## Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MRN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male Female

## Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. REFERRING CLINICIAN**

##### Referring Clinician.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ referring hospital\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cons IMC no.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### clinician contact phone/e-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax number for report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Insurance : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medical Insurance No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan Type \_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- |
| 3. SPECIFY STUDY AND Indication |   |
| Diagnosis and History:Histologically Proven: Yes No  | SCAN TYPE: FDG PET/CTstandard oncology body total body oncology (melanoma/myeloma) brain **other (discuss in advance)**   |
| REASON FOR PET/CT**Diagnosis** **Staging** **Restaging after Therapy** **Monitoring Response** **Suspected Recurrence**  | **Date Last:****Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Chemotherapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Radiotherapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**G-CSF (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **isolation/precautions (MRSA/c. diff/ tb etc.):**  | **pregnant/breast feeding: Yes No** **Lmp Date :**  |
| **Creatinine Level \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE** | **Diabetic Yes No**  |
| History | when | **where** |
| **Previous PET/CT Yes No**  |  |  |
| Previous CT/ MRI Yes No  |  |  |

#### Instruction for referring doctor & patient

* Low carbohydrate diet on day before study. Drink **only** water on day of scan.
* All In-patients must have IV Cannula placed.
* **No** food after midnight of study before 1pm. **No** food after 7am if study is after 1pm
* Stop TPN/ IV Dextrose at midnight before study.
* **ALL RECENT RELEVANT PET/CT/MRI EXAMINATION MUST ACCOMPANY PATIENT ON DISC OR PREFERABLY BE FORWARDED TO SJH PET CT CENTRE PRIOR TO STUDY TO ALLOW PRELOADING ONTO PACS**

**Referring Doctors signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Contact Details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_