JABATAN PERUBATAN NUKLEAR
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Pusat Pentadbiran Kerajaan Persekutuan
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REQUEST FOR MYOCARDIAL PERFUSION STUDY (TO BE FILLED IN 2 COPIES)

ATTENTION: RADIOISOTOPE STUDY WILL NOT BE PERFORMED IN PREGNANT WOMAN

Patient's Name:		**Gender: Male / Female**	**Ethnic Group:**
IC Number:	**Date of Birth:**	**Age:**	**Contact No:**
Address:			

Patient's Medical History

Indication:

Please √ in one of the most appropriate box:

- ☐ Detection of CAD : Symptomatic
- ☐ Detection of CAD / Risk Assessment : Asymptomatic / Without ischemic equivalent
- ☐ Risk Assessment with prior stress/rest test results and / or known chronic stable CAD
- ☐ Risk Assessment : Preoperative evaluation for non-cardiac surgery
- ☐ Risk Assessment : After an acute coronary syndrome
- ☐ Risk Assessment : Post-revascularization (PTCA or CABG)
- ☐ Evaluation of myocardial viability:
  - ☐ Known severe LV Dysfunction
  - ☐ Patient eligibility for revascularization

1. Does this patient have the following?

- ☐ H/O prior infarction. If yes, any thrombolytic agent given before? ☐ NO / ☐ YES
- ☐ ECG Changes – Q Waves
- ☐ ECG Changes – ST segment & T wave changes
- ☐ None of the above

Total Cholesterol:
TG:
HDL:
LDL:

2. Previous echocardiography done: ☐ NO / ☐ YES : If yes, the last done on:

Findings:

EF_________%

3. Previous exercise stress test done: ☐ NO / ☐ YES : If yes, the last done on:

Result: ☐ Positive Stress Test ☐ Normal Stress Test ☐ Inconclusive ☐ Not known

4. Previous Coronary angiography done: ☐ NO / ☐ YES : If yes, the last done on:

Findings:

5. History of PTCA or CABG: ☐ NO / ☐ YES : If yes, the last done on:

Results:

List of Current Medications:

What would your management plan be if this myocardial perfusion study / viability study is not available?

- ☐ Proceed with diagnostic coronary angiography +/- revascularization (PTCA/CABG)
- ☐ Proceed with revascularization procedure (PTCA/CABG)
- ☐ Observe and monitor only
- ☐ Continue with medical management and observed
- ☐ Source for other diagnostic modality: ☐ CTA ☐ Cardiac MRI ☐ Cardiac PET
- ☐ Others, please specify:

Date of Referral:

Date of next PC/Cardiology Clinic Appointment:

Signature of Requesting Doctor & Official Stamp: Name: Department:	**Signature of Requesting Specialist & Official Stamp:** Name: Department:
APPOINTMENT DATE FOR MYOCARDIAL PERFUSION SCAN: **DATE:** **TIME:**	**PATIENT PREPARATION:** Advice patient to bring all their current medications for verification prior taking the appointment and prior to test.