

PET-CT Imaging Request Form

National Cancer Institute

Please fill up the relevant information with a copy of pathology and relevant imaging results and fax the form to 03-83124377.

Appointment will be given once completed form is submitted.

Please call 03-83145501 for confirmation.

Patient's Name:		Gender :	Ethnic group :
I/C No :	Date of Birth :	Age :	Contact No :
Address :			
City/Town :		Postcode :	State :

Appointment Date: <small>(to be filled by PET-CT staff)</small>

Relevant medical history :			
Diabetic?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(Medication): _____
Claustrophobic?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Drug allergy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(Medication): _____
Pregnant?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(LMP: _____)

Type of study : <input type="checkbox"/> ¹⁸ F-FDG <input type="checkbox"/> ⁶⁸ Ga-DOTATOC / DOTATATE / DOTANOC <input type="checkbox"/> ⁶⁸ Ga PSMA

Clinical Diagnosis: <small>(please specify stage of disease)</small>
--

Primary site of disease :

Reason For PET/CT study :	
Oncology <input type="checkbox"/> Evaluation of unknown primary <input type="checkbox"/> Evaluation of solitary pulmonary nodule <input type="checkbox"/> Staging of newly diagnosed malignancy <input type="checkbox"/> Restaging when clinical/structural suspicion of recurrence or rising trend of tumor marker <input type="checkbox"/> Evaluation of post-treatment response <input type="checkbox"/> Identification of biopsy site for cancer <input type="checkbox"/> Surveillance <input type="checkbox"/> Evaluation of non-iodine avid disease	Neurology <input type="checkbox"/> Evaluation of inter-ictal seizure focus <input type="checkbox"/> Evaluation of dementia Cardiology <input type="checkbox"/> Evaluation cardiac viability Infection / Inflammation <input type="checkbox"/> Evaluation of pyrexia of unknown origin <input type="checkbox"/> Other:
Concise clinical summary:	

Relevant Findings (please fill up all applied) :

Clinical examination

Findings :

Surgery / Histopathology

(Date)

Findings :

Imaging : CT / MRI / PET-CT

(Date)

Findings :

Others: (ie CEA / CA 125 / CgA / Ki-67/ PSA level) (Date)

Treatment?

Yes

No

Surgery

(Date: _____, Site: _____)

Radiotherapy

(Date: _____, Site: _____)

Chemotherapy

(Date: _____, Regime: _____)

Type of Appointment Required:

Urgent

Normal

Early/Preferred Date

Referring consultant / specialist:

Name : _____

Signature & Official Stamp :

Title : _____

Tel. No : _____

Hospital : _____

Fax. Add : _____

Date of referral : _____

Email Add : _____

* Referring doctor may be called to clarify request.

Check list:

- Completed form with specialist signature & official stamp
- Pathology report
- Imaging (US, CT, MRI, NM imaging) report
- Contactable phone number (patient and referring doctor)
- Imaging film or CD for patient to bring along during appointment