Alliance Medical

NHS

Poole Hospital
PET/CT Patient Request Form

Please refer to page 2 for the contraindications to PET/CT

Please complete all the sections on this page. Failure to do so may delay appointment being made.

PATIENT DETAILS

HOSPITAL NO: **NHS NO:**

Title: First name: Surname:

Accession No:

Address:

Postcode: Inpatient ☐ Outpatient ☐

Email:

Tel no: Mobile:

Date of Birth: Next of Kin:

G.P. Details: Title: Surname:

Surgery address:

Patient arrival: Trolley ☐ Wheelchair ☐ Walking ☐

Funding: NHS ☐ Self Funded ☐ Insured ☐

Research patient: Commercial ☐ Non-commercial ☐

REC Trial No: XX / XX / XXXX

Trial name:

Patient's insurance company:

Membership number:

Pre-authorisation number (if known):

Is an interpreter required? Yes ☐ No ☐

Is transport required? Yes ☐ No ☐

MEDICAL HISTORY

Has the patient had any surgery in the last six weeks?
If yes, please list procedure and anatomical site:

CLINICAL INDICATIONS

Reason for referral: (including any surgery, current medication and correlative imaging):

2 week wait? Yes ☐ No ☐

62 day target patient? Yes ☐ No ☐

Last diagnostic PET/CT: Date: Body area:

Last diagnostic CT: Date: Body area:

Last diagnostic MRI: Date: Body area:

PLEASE ENSURE YOU SEND A COPY OF THE LATEST CT/MRI REPORTS WITH THE REQUEST FORM

	Chemotherapy	Radiotherapy
Type:		
Cycle length:		
Date of last treatment:		
Date of next treatment:		
MDT date:		
Breach date:		
Requested date for scan:		

SAFETY CHECK

Could the patient be pregnant? Yes ☐ No ☐

Is the patient breast feeding? Yes ☐ No ☐

Is the patient claustrophobic? Yes ☐ No ☐

Does the patient have mobility issues? Yes ☐ No ☐

Is the patient part of a trial? Yes ☐ No ☐

If yes, please specify:

Approximate Weight:

Is the patient known to carry a high risk infection ? Yes ☐ No ☐

If yes, please specify:

Does the patient have any known allergies? Yes ☐ No ☐

If yes, please specify:

Does the patient suffer from diabetes? Yes ☐ No ☐

Is the diabetes controlled by: Diet ☐ Insulin ☐ Tablet ☐

Does the patient suffer from incontinence? Yes ☐ No ☐

REFERRING CLINICIAN DETAILS

IR(ME)R2000 regulations require this form to be signed by the referring Consultant:

GMC Number:

Email:

Print Name: Date:

Hospital: **Poole Hospital**

Address: **Longfleet Road, Poole BH15 2JB**

Tel:

Consultant Signature:

On completion please print, sign, scan and email to: poh-tr.PoolePETS@nhs.net

AM000287 Nov 2015

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Patient Name	Date of Birth

CLINICAL INDICATION CODING (please tick one box from each table):

Lung	☐		Staging	JA ☐
Oesophagus	☐		Re-staging	JB ☐
Colorectal	☐		Recurrence	JC ☐
Lymphoma	☐		Residual Mass	JD ☐
Head & Neck (includes H&N unknown primary)	☐	Please state:	Follow Up (response to therapy)	JE ☐
Melanoma	☐		Characterisation	JF ☐
Unknown Primary (excludes H&N unknown primary)	☐		Pre-resection Metastases	JG ☐
Upper GI (includes Stomach, Small Bowel, Liver, Pancreas)	☐	Please state:	Find Unknown Primary	JH ☐
Sarcoma	☐		Elevated Tumour Markers	JI ☐
Breast	☐		Paraneoplastic Syndrome	JJ ☐
Urological (includes Renal, Adrenal, Bladder, Prostate, Testicle)	☐	Please state:	Other Oncology	JK ☐
Gynaecological (includes Ovary, Uterus, Cervix)	☐	Please state:	Non-Oncology: Neurology	JL ☐
Brain & Spinal Cord	☐	Please state:	Non-Oncology: Cardiac	JM ☐
Oncology: Other	☐	Please state:	Non-Oncology: Other	JN ☐
Non-Oncology: Neurology	☐			
Non-Oncology: Cardiac	☐			
Non-Oncology: Other (includes vasculitis, infection imaging)	☐	Please state:		

ARSAC PROCESS - ARSAC Certificate Holder or Delegate to complete

ARSAC Authorisation (please indicate) ☐ Pre-referral to PMC ☐ Under delegation

Protocol required:

- Vertex to toes PET/CT ☐
- Base of skull to proximal third of femur PET/CT ☐
- Lung Apices to proximal third of femur PET/CT ☐
- Symphysis pubis to toes PET/CT ☐
- Vertex to proximal third of femur PET/CT ☐
- Vertex to Lung Apices PET/CT ☐
- Brain PET/CT ☐
- Other (please specify) ☐
- Prostate - Dynamic PET/CT ☐
- Other - Dynamic PET/CT ☐

Tracer required: FDG ☐ FEC ☐ NaF ☐ Amyloid ☐

Other (please state) ☐

Can patient be scanned in Radiotherapy Planning Position? Yes ☐ No ☐

Clinical authorisation by ARSAC certificate holder or delegate:

Print Name:

Signature:

Date:

SPECIFIC CLINICAL CONTRAINDICATIONS TO PET/CT INCLUDE: Pregnancy or suspected pregnancy

Clinical contraindications rendering the patient medically unfit to undergo the scan include:
Chest drains in situ, Influenza, Chickenpox (Varicella Zoster Virus), Measles (Rubella), Mumps, Clostridium Difficile (may only be scanned at static centres), Whooping cough (Bordetella pertussis), Active Shingles (Herpes Zoster), Diphtheria (Corynebacterium diphtheriae)

Additional physical and technical contraindications to PET/CT include:

Inability to cooperate with the scan process - For instance, inability to lie relatively still for 1-2 hours and to lie supine for 30-60 minutes

Blood Glucose Level - If the patient's blood glucose level is outside the ARSAC certificate holder's agreed limits. In patients with diabetes this must be adequately controlled prior to attendance for the PET/CT scan. Uncontrolled blood glucose levels may result in sub-optimal or undiagnostic image quality and therefore in these circumstances the patient's appointment may be cancelled and re-scheduled for an alternative date when diabetic control has been established

Chemotherapy/Radiotherapy - If the patient's appointment date is outside the ARSAC certificate holders agreed time limits

Patient body habitus above scanner dimensions - Scanner Bore Diameter 70cm (distance from scanner bed to roof of scanner approximately 50cm). If it is uncertain if a patient's body habitus will prevent us from proceeding with the scan the patient may be invited to attend the scanner prior to their appointment date to undergo a trial run through the scanner gantry