

Dorset Healthcare University 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 <input type="checkbox"/> Outpatient <input type="checkbox"/> Email: _____ Tel no: _____ Mobile: _____ Date of Birth: _____ Next of Kin: _____		Patient arrival: Trolley <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walking <input type="checkbox"/> Funding: NHS <input type="checkbox"/> Self Funded <input type="checkbox"/> Insured <input type="checkbox"/> Research patient: Commercial <input type="checkbox"/> Non-commercial <input type="checkbox"/> REC Trial No: <input type="text" value="XX / XX / XXXX"/> Trial name: _____ Patient's insurance company: _____ Membership number: _____ Pre-authorisation number (if known): _____ Is an interpreter required? Yes <input type="checkbox"/> No <input type="checkbox"/> Is transport required? Yes <input type="checkbox"/> No <input type="checkbox"/>	
G.P. Details: Title: _____ Surname: _____ Surgery address: _____		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: **Dorset HealthCare University NHS Foundation Trust**
 Address: **Sentinel House, Nuffield Industrial Estate, Nuffield Road, Poole BH17 0RB**
 Tel: _____
 Consultant Signature: _____

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

Patient Name	Date of Birth
CLINICAL INDICATION CODING (please tick one box from each table):	
Lung <input type="checkbox"/>	Staging JA <input type="checkbox"/>
Oesophagus <input type="checkbox"/>	Re-staging JB <input type="checkbox"/>
Colorectal <input type="checkbox"/>	Recurrence JC <input type="checkbox"/>
Lymphoma <input type="checkbox"/>	Residual Mass JD <input type="checkbox"/>
Head & Neck (includes H&N unknown primary) <input type="checkbox"/> Please state:	Follow Up (response to therapy) JE <input type="checkbox"/>
Melanoma <input type="checkbox"/>	Characterisation JF <input type="checkbox"/>
Unknown Primary (excludes H&N unknown primary) <input type="checkbox"/>	Pre-resection Metastases JG <input type="checkbox"/>
Upper GI (includes Stomach, Small Bowel, Liver, Pancreas) <input type="checkbox"/> Please state:	Find Unknown Primary JH <input type="checkbox"/>
Sarcoma <input type="checkbox"/>	Elevated Tumour Markers JI <input type="checkbox"/>
Breast <input type="checkbox"/>	Paraneoplastic Syndrome JJ <input type="checkbox"/>
Urological (includes Renal, Adrenal, Bladder, Prostate, Testicle) <input type="checkbox"/> Please state:	Other Oncology JK <input type="checkbox"/>
Gynaecological (includes Ovary, Uterus, Cervix) <input type="checkbox"/> Please state:	Non-Oncology: Neurology JL <input type="checkbox"/>
Brain & Spinal Cord <input type="checkbox"/> Please state:	Non-Oncology: Cardiac JM <input type="checkbox"/>
Oncology: Other <input type="checkbox"/> Please state:	Non-Oncology: Other JN <input type="checkbox"/>
Non-Oncology: Neurology <input type="checkbox"/>	
Non-Oncology: Cardiac <input type="checkbox"/>	
Non-Oncology: Other (includes vasculitis, infection imaging) <input type="checkbox"/> Please state:	

ARSAC PROCESS - ARSAC Certificate Holder or Delegate to complete	
ARSAC Authorisation (please indicate) <input type="checkbox"/> Pre-referral to PMC <input type="checkbox"/> Under delegation <input type="checkbox"/>	
Protocol required: Vertex to toes PET/CT <input type="checkbox"/> Base of skull to proximal third of femur PET/CT <input type="checkbox"/> Lung Apices to proximal third of femur PET/CT <input type="checkbox"/> Symphysis pubis to toes PET/CT <input type="checkbox"/> Vertex to proximal third of femur PET/CT <input type="checkbox"/> Vertex to Lung Apices PET/CT <input type="checkbox"/> Brain PET/CT <input type="checkbox"/> Other (please specify) <input type="checkbox"/> Prostate - Dynamic PET/CT <input type="checkbox"/> Other - Dynamic PET/CT <input type="checkbox"/>	Tracer required: FDG <input type="checkbox"/> FEC <input type="checkbox"/> NaF <input type="checkbox"/> Amyloid <input type="checkbox"/> Other (please state) <input type="checkbox"/> Can patient be scanned in Radiotherapy Planning Position? Yes <input type="checkbox"/> No <input type="checkbox"/> Clinical authorisation by ARSAC certificate holder or delegate: Print Name: Signature: Date:

<p>SPECIFIC CLINICAL CONTRAINDICATIONS TO PET/CT INCLUDE: Pregnancy or suspected pregnancy</p> <p>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)</p> <p>Additional physical and technical contraindications to PET/CT include:</p> <p>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</p> <p>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</p> <p>Chemotherapy/Radiotherapy - If the patient's appointment date is outside the ARSAC certificate holders agreed time limits</p> <p>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</p>
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