Pacific Radiology

PET/CT Referral Form

Patient's Name ....

Address .... DOB ....

.... NHI# ....

.... Tel (mob) ....

Email .... Tel (hme) ....

MEDICAL INSURANCE? ☐ YES ☐ NO Provider .... Policy # ....

HEALTHNZ: ☐ HNZ of Domicile .... ☐ HNZ of Service ....

Discussed at an MDM? ☐ MDM Name ....

EXAMINATION REQUESTED

....

☐ FDG ☐ NAF ☐ FET (brain) ☐ PSMA ☐ Other .... Timing of scan ....

IMPORTANT SAFETY QUESTIONS - REFERRING CLINICIAN PLEASE COMPLETE

Diabetic? ☐ IDDM ☐ NIDDM ☐ No ☐ Outpatient ☐ Inpatient Ward ....

Is your patient pregnant? ☐ Yes ☐ No

Is your patient infectious? ☐ Yes ☐ No Comment: ....

Does your patient have allergies? ☐ Yes ☐ No Comment: ....

Renal Failure? ☐ Yes ☐ No

eGFR/date .... (within 3 months)

Previous IV contrast reactions? ☐ Yes ☐ No

Does your patient have asthma? ☐ Yes ☐ No

Interpreter needed? ☐ Yes ☐ No

DOES YOUR PATIENT REQUIRE:

Sedation ☐ Yes ☐ No

General Anaesthetic ☐ Yes ☐ No

Approx. weight of patient .... kg

Approx. height of patient .... cm

Ensure both sides of this form are completed and that it is signed by the referring consultant, email the completed form to petct@prg.co.nz.

HEALTHNZ FUNDED SCANS: Complete the form & give to your Department Administrator.

REFERRER DETAILS

Name .... Team ....

Address ....

Secretary Name .... Fax .... Phone ....

Signature .... Date ....

COPY TO:

Name .... Fax ....

Address ....

Name .... Fax ....

Address ....

CLINICAL AUDIT - PLEASE FILL IN OR TICK APPROPRIATE RESPONSES FOR ALL CASES

PRIMARY CONDITION ....

Histology / Pathology ....

Please select one of the following:

- ☐ New diagnosis / Initial staging
- ☐ Restaging / Surveillance
- ☐ Assess RX response

Previous malignancies ....

Clinical details

....

....

....

....

KNOWN EXTENT OF DISEASE *[select all that apply]*

- ☐ No evidence of disease Site ....
- ☐ Primary lesion Site ....
- ☐ Local recurrence Site ....
- ☐ Loco-regional involvement Site ....
- ☐ Systemic disease Site ....
- ☐ Equivocal Site ....

RECENT TREATMENT DETAILS

☐ Surgery: Site .... Date ....

☐ Radiotherapy ☐ Chemotherapy ☐ Combined

Date of last Radio/Chemo treatment ....

Date of next Radio/Chemo treatment ....

RECENT RELEVANT IMAGING

☐ CT Date .... Provider ....

☐ MRI Date .... Provider ....

☐ PET Date .... Provider ....

☐ Other Date .... Provider ....

WHAT WOULD YOUR MANAGEMENT PLAN BE IF PET WERE UNAVAILABLE?

Intention of plan: ☐ Curative or ☐ Palliative

☐ Surgery	☐ Radiotherapy	☐ Chemoradiation alone
☐ Chemoradiation then surgery	☐ Chemotherapy alone	☐ Chemotherapy then surgery
☐ Biopsy	☐ Observation only	☐ Other ....

HEALTHNZ APPROVED INDICATIONS - THIS MUST BE COMPLETED FOR ALL HNZ FUNDED CASES

ANAL	☐ AN1 ☐ AN2
BLADDER	☐ BL1
BREAST	☐ BR1
CARDIAC SARCOID	☐ CS1
COLORECTAL	☐ CR1 ☐ CR2 ☐ CR3 ☐ CR4
EPILEPSY	☐ EP1
GERM CELL	☐ GE1
GIST	☐ GI1
GLIOMA	☐ GL1 ☐ GL2
GRAFT INFECTION	☐ GR1
CERVICAL	☐ GY1 ☐ GY2 ☐ GY4
HEPATOBILIARY	☐ HB2
HEAD & NECK	☐ HN0 ☐ HN1 ☐ HN3
LUNG	☐ LU1 ☐ LU2
PANCREAS	☐ PANC1
PROSTATE	☐ PROS1 ☐ PROS2
PYREXIA OF UNKNOWN ORIGIN	☐ PU1
SARCOMA	☐ SA1 ☐ SA2
THYROID	☐ TH1
SKIN	☐ SK1 ☐ SK2 ☐ SK3
TESTICULAR CANCER	☐ TE1
LYMPHOMA	☐ LYM1 ☐ LYM2 ☐ LYM3 ☐ LYM4 ☐ LYM5 ☐ LYM6 ☐ LYM7
MYELOMA	☐ MY1
NEUROENDOCRINE	☐ NE1 ☐ NE2
OESOPHAGUS	☐ OE1 ☐ OE2
OVARIAN	☐ OV1

OTHER: The condition is outside the above criteria; however, I have discussed the patient with a PET/CT subject matter expert who has supported this scan request.

PET/CT Radiologist or NM Specialist: ....