Pacific Radiology

PET-CT Imaging Referral Form

Patient's Name ....

Address .... DOB ....

.... NHI# ....

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

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

ACCIDENT ☐ YES ☐ NO ACC No. .... Date of injury ....

COVERED BY: ☐ ACC ☐ Accredited Employer ....

[name of employing company]

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

DHB: ☐ DHB of Domicile ☐ DHB of Service ....

Discussed at an MDM? ☐ MDM Name ....

EXAMINATION REQUESTED

....

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

Date results required .... If URGENT, reason ....

IMPORTANT SAFETY QUESTIONS - REFERRING CLINICIAN PLEASE COMPLETE

Diabetic? ☐ IDDM ☐ NIDDM ☐ No

Is your patient pregnant? ☐ Yes ☐ No

Does your patient have allergies? ☐ Yes ☐ No

Comment: ....

Renal Failure? ☐ Yes ☐ No

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

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

Previous IV contrast reactions? ☐ Yes ☐ No

Does your patient have asthma? ☐ Yes ☐ No

☐ Outpatient ☐ Inpatient Ward ....

Is your patient infectious? ☐ Yes ☐ No

Comment: ....

Interpreter needed? ☐ Yes ☐ No

Approx. weight of patient .... kg

Approx. height of patient .... cm

DOES YOUR PATIENT REQUIRE:

Sedation ☐ Yes ☐ No

General Anaesthetic ☐ Yes ☐ No

IMPORTANT NOTES - FOR REFERRING CLINICIAN

Ensure both sides of this form are completed and that it is signed by the referring consultant, email the completed form to appointments@pacificradiology.com or fax to 04 978 5501.

DHB FUNDED SCANS: Complete the form & give to your DHB 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
- ☐ Chemoradiation then surgery
- ☐ Biopsy
- ☐ Radiotherapy
- ☐ Chemotherapy alone
- ☐ Observation only
- ☐ Chemoradiation alone
- ☐ Chemotherapy then surgery
- ☐ Other ....

DHB APPROVED INDICATIONS - MUST BE COMPLETED FOR ALL DHB FUNDED CASES

Indication	Codes
COLORECTAL	☐ CR1 ☐ CR2 ☐ CR3
ANAL	☐ AN1 ☐ AN2
LUNG	☐ LU1 ☐ LU2 ☐ LU3
LYMPHOMA	☐ LY1 ☐ LY2 ☐ LY3 ☐ LY4 ☐ LY5
HEAD & NECK	☐ HN1 ☐ HN2 ☐ HN3
OESOPHAGUS	☐ OE1
SKIN	☐ SK1 ☐ SK2
CERVICAL	☐ GY1 ☐ GY2
OVARIAN	☐ GY3
EPILEPSY	☐ EP1
GIST	☐ GT1
SARCOMA	☐ SA1 ☐ SA2
NEUROENDOCRINE TUMOUR	☐ NE1
THYROID	☐ TH1
GLIOMA	☐ GL1 ☐ GL2
HEPATOBILIARY	☐ HB1 ☐ HB2
GRAFT INFECTION	☐ GR1
TESTICULAR	☐ TE1

OTHER: If the condition is outside the above criteria it will need to be approved by the PET Variance Committee. Please forward your request and supporting information to the relevant PET Scan Variance Committee.
Email: RES-Petscanning@ccdhb.org.nz

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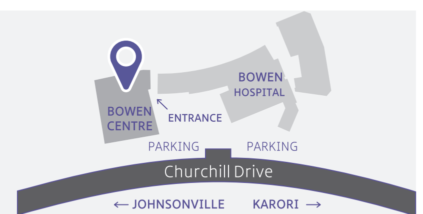
PET Variance Committee Authorisation

....
DHB Department Administrator

PACIFIC RADIOLOGY BOWEN CENTRE
98 Churchill Drive
Wellington 6035
Phone (04) 978 5500 ext 5535 **Fax** (04) 978 5501
Hours Weekdays 8am - 4.30pm



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