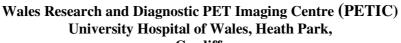


PET/CT SCAN REQUEST FORM

Please mail or fax to:





Cardiff, CF14 4XW

Tel No:029 20746880/1 Fax No:029 20746879 Target Patient for 31/62 day pathway? Y/N

Failure to complete ALL relevant sections of this form may result in a delay

PATIENT DETAILS		REFE	RRING CLINICIAN	S DETAILS	
Hospital No/NHS No:		Name:			
Name:		Hospit	al:		
Date of Birth:	M	/F Addre	ss:		
Address:					
Postcode:					
	Ward	Tel No		Bleep:	
Home Tel No:			Fax No for Report:		
Mobile No:			Email for confirmation		
		of app		D /	
Transport: AMBULANCE □ 0	CHAIR 🗆	Signat	ure:	Date:	
-					
BED □ WALKING	} <u> </u>				
FUNDING NHS	TRIAL [SELF FUNDI	NG PRIVATE		
CLINICAL DETAILS (DI		· 41	1	4	
CLINICAL DETAILS (Plea	ise state reason j	or tne request ana	now it may affect patien	t management)	
Please include details of any recent xrays and scan reports					
Please complete where relevant					
Recent Surgery/Biopsy (please specify):					
Radiotherapy (please specify):					
Radiotherapy (please specify).		• • • • • • • • • • • • • • • • • • • •	•••••	• • • • • • • • • • • • • • • • • • • •	
Chemotherapy (Date last cycle	e completed):				
enemoticiapy (Bate last eyen	, compreted,				
Safety Check					
Could the patient be pregnant?	Yes No		Does the patient have any all	lergies? Yes No	
	v		TC 1		
Is the patient breast feeding?	Yes No		If yes, please specify:		
Is there an infection risk?	Yes No		Is the patient diabetic?	Yes No	
If yes, please specify?			Diabetic Control Diet	Insulin Tablet	
PET Centre use only:					
	.		.		
Signature (ARSAC certificate holder)	Priority (1-3)	Indication (disease category)	Protocol (local views etc)	Outside imaging to request?	
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