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INITIO

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REQUEST FOR DIAGNOSTIC CT or PET/CT

• Patient Information •

Name		Date of Birth	____ / ____ / ____ DD MMM YYYY
Address		Care Card (PHN)	
City		E-mail	
Postal/Zip Code		Sex ☐ Male ☐ Female	
Phone Number		Weight lbs/kg	Height: ft'in/cm

• Examination Requested •

PET/CT ☐ CT only ☐	Iodine Contrast ☐ *(Please check box if IV contrast is required for the scan requested, a default study will be non-contrast)*	eGFR _____ Creatinine _____ Date _____

• Clinical Indication(s) •

Does this patient have a known malignancy
☐ Yes ☐ No Type(s): _____

For Internal Use Only

• Additional Patient Information •

Diabetic ☐ Yes ☐ No ☐ Metformin ☐ Insulin Fasting BGL _____	Claustrophobic ☐ Yes ☐ No Allergies ☐ Yes ☐ No Specify _____	Impaired Mobility ☐ Yes ☐ No Breast Feeding ☐ Yes ☐ No Pregnant ☐ Yes ☐ No

• Relevant Diagnostic Imaging (Please attach reports of imaging) •

Previous PET Scan	☐ Yes ☐ No	Other Medical Imaging	☐ Yes ☐ No
Date of Scan		Type (MRI, bone scan, CT, etc)	
Hospital/Clinic		Hospital/Clinic	

• Treatments •

Chemotherapy ☐ Yes ☐ No	Surgery/Biopsy ☐ Yes ☐ No	Radiotherapy ☐ Yes ☐ No
____ / ____ / ____ DD MMM YYYY	____ / ____ / ____ DD MMM YYYY	____ / ____ / ____ DD MMM YYYY

• Referring Physician Information •

Name		Phone Number	
MSP #		Fax Number	
Signature		Email address	
CC copy to GP:		Date	

• Please fax completed form to 604.678.9279 or e-mail to info@initiomedical.ca •