

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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Phone Number		Weight	lbs/kg Height: ft/in/cm
• Examination Requested •			
PET/CT	<input type="checkbox"/>	FDG	<input type="checkbox"/>
CT only	<input type="checkbox"/>	NeuraCeq	<input type="checkbox"/>
		⁶⁸ Gallium-DOTATATE	<input type="checkbox"/>
		For DOTATATE scans: Is the patient on Somatostatin therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
• Clinical Indication(s) •			
		For Internal Use Only	
Does this patient have a known malignancy <input type="checkbox"/> Yes <input type="checkbox"/> No Type(s): _____		Please include relevant reports	
• Additional Patient Information •			
Diabetic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Claustrophobic	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Metformin <input type="checkbox"/> Insulin	Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fasting BGL	_____	Specify	_____
Impaired Mobility	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast Feeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No		
• Relevant Diagnostic Imaging (Please attach reports of imaging) •			
Previous PET Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Medical Imaging	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Scan		Type (MRI, bone scan, CT, etc)	
Hospital/Clinic		Hospital/Clinic	
• Treatments •			
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Surgery/Biopsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Radiotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No		
____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
DD MMM YYYY	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 •			