

## REQUEST FOR DIAGNOSTIC CT OR PET/CT

• Patient Information •					
Name		Date of Birth	____ / ____ / ____	DD	MMM / YYY
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"/>	For DOTATATE scans:	
CT only	<input type="checkbox"/>	Neuraceq	<input type="checkbox"/>	Is the patient on Somatostatin therapy?	
		<sup>68</sup> Gallium-DOTATATE	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
• Clinical Indication(s) •					
Does this patient have a known malignancy <input type="checkbox"/> Yes <input type="checkbox"/> No   Type(s): _____			For Internal Use Only  <b>Please include relevant reports</b>		
• Additional Patient Information •					
Diabetic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Claustrophobic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Impaired Mobility	<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	Breast Feeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fasting BGL	_____	Specify	_____	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   YYY		DD   MMM   YYY		DD   MMM   YYY
• 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 •					