Eastern Health
Diagnostic Imaging

Request for Positron Emission Tomography (PET) Imaging

IV2490 1556 01 2017

Allergies: ❑ No Known

Name: _____

HCN: _____

Date of Birth: DD/MONTH/YYYY

Address: STREET, TOWN, POSTAL CODE

Telephone: _____

❑ Inpatient – Unit _____ ❑ Outpatient

Patient Transport: ❑ Bed ❑ Stretcher ❑ Wheelchair

❑ MCP ❑ WCC ❑ NR ❑ DVA ❑ DND ❑ Other: _____

Physician Information (please use stamp)

The ordering physician is responsible to follow-up on the exam report.

Physician Signature: _____

Date: DD/MONTH/YYYY

Copy report to (please print): _____

Indications for Study

❑ Staging ❑ Assess Treatment Response

❑ Restaging ❑ Indeterminate Solitary Pulmonary Nodule

❑ Characterize Mass/Lesion

❑ Other (Specify): _____

Identify Urgency

Based on clinical assessment, Nuclear Medicine Physician consult may be indicated.

❑ Urgent ❑ Non-urgent

❑ Follow-up (Specify Date): DD/MONTH/YYYY

Clinical History: _____

Suspected Diagnosis: _____ Patient Medications: _____

Treatment History

	Yes	No	Start Date	Completed
Radiotherapy:	❑	❑	DD/MONTH/YYYY	DD/MONTH/YYYY
Chemotherapy:	❑	❑	DD/MONTH/YYYY	DD/MONTH/YYYY
Marrow Stimulant Therapy:	❑	❑	DD/MONTH/YYYY	DD/MONTH/YYYY
Other:	❑	❑	DD/MONTH/YYYY	DD/MONTH/YYYY

	Procedure	Date
Surgery/Biopsy:	_____	DD/MONTH/YYYY
Surgery/Biopsy:	_____	DD/MONTH/YYYY
Surgery/Biopsy:	_____	DD/MONTH/YYYY

Relevant Previous Imaging

(PET / Computed Tomography / Magnetic Resonance Imaging)

Exam	Date	Location
_____	DD/MONTH/YYYY	_____
_____	DD/MONTH/YYYY	_____
_____	DD/MONTH/YYYY	_____
_____	DD/MONTH/YYYY	_____
_____	DD/MONTH/YYYY	_____

Complete for Exams Requiring IV Contrast

Are there any of the following risk factors for contrast induced nephropathy (CIN)? ❑ Yes ❑ No

Risk Factors: Age greater than 70 years, Diabetes Mellitus, renal disease, Nephrotoxic drugs, organ transplant, chemotherapy, cardiovascular disease, single kidney.

If risk factor is present, please provide the patient's current* estimated GFR _____

Date of last GFR: DD/MONTH/YYYY

**Outpatient: less than 6 months; Inpatient: less than 7 days*

Safety Checklist

Can patient lie still/supine for 30 minutes? ❑ Yes ❑ No

Is patient incontinent? ❑ Yes ❑ No

Is patient claustrophobic? ❑ Yes ❑ No

Is patient diabetic? ❑ Yes ❑ No

❑ Type I Insulin Type(s): _____

❑ Type II ❑ Controlled by Diet Alone

❑ Oral Hypoglycemics (specify) _____

❑ Insulin (specify) _____

For Diagnostic Imaging Use Only

Ordering Physician Notified: ❑ *Phone* ❑ *Message* ❑ *Mail*

Date Received: DD/MONTH/YYYY

Patient Preparation Instructions: ❑ *Yes* ❑ *No*

Patient Notified: ❑ *Phone* ❑ *Message* ❑ *Mail*

IV Contrast: ❑ *Yes* ❑ *No* *Sedation:* ❑ *Yes* ❑ *No*

Nuclear Medicine Physician: _____

Date: DD/MONTH/YYYY

Priority: _____

Protocol: _____

_____

Name: _____ *Signature:* _____