PET SCANNING REQUEST FORM

Bupa CROMWELL HOSPITAL

PET Scanning dept telephone 020 7460 5542/5541 | PET Scanning dept fax 020 7835 2403

PLEASE BRING THIS FORM WITH YOU WHEN YOU ATTEND THE HOSPITAL
All sections of this form must be fully completed

Appointment:

Date _____ Time _____

Referring Consultant _____

Report / CD to _____

Patient details: Place sticker here

Name _____

DOB _____

MRN _____ Sex [M] [F]

Pregnant [Y] [N]

LMP _____ Patient Signature _____

Is the patient diabetic? [Y] [N]

If yes, how is this managed? Diet / Tablets / Insulin

PATIENT TO BRING PREVIOUS X-RAYS OR SCANS

Information required for compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 and good practice for all Diagnostic Imaging.

PLEASE COMPLETE ALL SECTIONS OF THIS REQUEST FORM. INCOMPLETE FORMS WILL BE RETURNED.

PET/CT Scan - includes low dose CT imaging

CLINICAL INFORMATION:

SEPERATE DIAGNOSTIC CT SCAN REQUIRED? [Y] [N]

If yes, please state which area is to be scanned _____

CONTRAINDICATIONS TO CONTRAST MEDIA:

Asthma, history of allergies, previous contrast, end stage kidney or heart failure, myeloma or sickle cell anaemia.

Patient's eGFR _____

Patient's Creatine _____

CT Imaging only

Protocoled by/no _____ Date _____

IR(ME)R Practitioner _____ Date _____

Operator _____ Date _____

Dose: CTDI vol: _____ mGy DLP: _____ mGy/cm

DATE AND SITE OF:

LAST CHEMOTHERAPY _____

NEXT CHEMOTHERAPY _____

RECENT RADIOTHERAPY _____

RECENT BIOPSY _____

RECENT SURGERY _____

IR(ME)R Practitioner _____ Date _____

(Under ARSAC)

Operator _____ Date _____

Referring Clinician Signature

Signature _____ Date _____

Guidance Notes for Referrers

In accordance with the Ionising Radiation (Medical Exposures) Regulation 2000, the Bupa Cromwell Hospital Radiology Department would like to make all Referrers aware of the following Guidelines:

Referrals:

- A request for a Radiological Examination will be regarded as a request from one Clinician or Health Professional to the Radiology Department for an opinion based upon a radiological examination to assist in the management of a clinical problem.
- Diagnostic Imaging or radiological procedures will only be performed upon a written request signed by a Registered Medical or Dental Practitioner or by an authorised Non-Medical Practitioner.
- Signed referrals (request form or letter) must precede or accompany the patient. Signed faxes are also accepted.
- All requests must carry sufficient information to identify the patient. This normally consists of first name, middle name if any, and family name, date of birth and address.
- All requests must carry sufficient clinical information to enable the requested examination to be justified. Referral criteria are based on the Royal College of Radiologists' Guidelines - "Making the best use of a Department of Clinical Radiology: Guidelines for Doctors".
- All requests shall clearly state the examination requested.
- All requests must include contact details of the Referring Clinician including address and telephone number.

Females of Childbearing Age (12-55 years)

- All requests for X-ray examinations (between the diaphragm and the knees) for females of childbearing age (12-55 years) must state the date of the first day of the patient's menstrual period.

Clinical Justification of Requests:

- All requests for imaging will be assessed prior to exposure by the appropriate Practitioner for the examination to ensure that they meet with The Royal College of Radiologists' Guidelines and any local Guidelines and that, in their professional judgement, they are clinically justified (Royal College of Radiologists Publication: BCFR(00)5).