

PET Imaging Request Form: Oncology

PLEASE COMPLETE BOTH SIDES & ENSURE FORM IS SIGNED BY THE REFERRING CONSULTANT SPECIALIST

Patient Information

- Is patient an inpatient? Yes / No Ward? _____
- Diabetic? No / IDDM / NIDDM
- Is patient claustrophobic? Yes / No
- Interpreter required? Yes / No
- Clinical Trial? Yes / No
- Please specify trial number and contact person:

- Patient's weight & height (kg and cm)

Patient Identification or ID Sticker

ALFRED UR NO: _____
 SURNAME: _____
 FIRST NAME: _____
 DATE OF BIRTH: _____
 ADDRESS: _____
 PHONE: Mobile/Other _____
 ***Required to contact
 pt. with instructions _____

Referring Consultant Specialist *Medicare requires that to be reimbursable, PET scans must be specialist referred

Specialist Name _____ Specialist Provider No: _____
 Phone contact: _____ Signature: _____
 Please specify address where CD & reports are to be sent: _____

 Fax (**required to ensure report delivery): _____ Date of Referral _____
 Date results required by: (Please indicate date or circle) _____ <3 days 1 week 2-3 weeks >1 month

Clinical Indication

Diagnosis Staging Restaging Therapeutic Monitoring Other _____
 Primary Site of Disease: _____ Histology/pathology: _____
 Treatment (esp recent): Nil Surgery Chemo Radio Hormone Immuno Other _____
 Rx Details/Recent Complications (eg inflam/infection): _____
 RT Planning Position Required Yes / No With RT Mask Yes / No
 Notes: (Please attach available imaging results eg CT/MRI and pathology results)

Recent correlative imaging

- CT Date:- _____ Provider/where:- _____
- MRI/Other Date:- _____ Provider/where:- _____

Please ensure patient brings external films with them

Planned Imaging

CT/MRI/US BOOKED DATE: _____
 OTHER BOOKED DATE: _____

Not for scanning into medical record

Please select appropriate clinical indication below and complete column appropriate to your selection. Medicare rebates are available to patients referred by a **specialist** if the clinical indication meets the following criteria.

***Patients referred for Unfunded PET scan indications may be charged \$800 or \$400 for Pension and Concession card holders. Overseas and screening patients will attract a charge of \$1,000 and are billed on the day of the scan.**

Staging/Diagnosis

- Solitary pulmonary nodule
- Staging of newly diagnosed **NSCLC (Lung cancer)** being considered for radical RT or surgery
- Staging of **Melanoma** with potentially resectable disease
- Staging of newly diagnosed **Cervical Cancer**
- Staging of newly diagnosed **Oesophageal cancer** being considered for radical RT or surgery
- Staging of newly diagnosed **Head & Neck Cancer**
- Evaluation of metastatic **Squamous Cell Carcinoma Cervical** nodes of unknown primary
- Staging of newly diagnosed **Low grade Non Hodgkin's Lymphoma prior to radiotherapy**
- Staging of newly diagnosed **High Grade Non Hodgkin's Lymphoma or Hodgkin's Lymphoma**
- Staging of newly diagnosed **Sarcoma**
- Other (Non Funded Clinical Indication)**

* Please refer to note at top of page

Please Specify _____

Stage by Clinical and/or Investigation Findings Performed Up to Time of Referral

T-stage Site: _____
 N stage Location: _____
 M stage Site(s): _____
 Or Stage _____

Based on;

- Clinical examination
- Pathology/Surgery
- CT/MRI/US (circle)
- Other _____

What would your management plan be if PET were unavailable#;

- Surgery
- Radical radiotherapy
- Radical chemoradiation
- Radical chemoradiation -> Surgery
- Neoadjuvant chemotherapy-> Surgery
- Systemic chemotherapy
- Palliative radiotherapy
- Invasive biopsy
- Observation
- Other _____

Management Plan intent

- Curative or Palliative

Restaging/Surveillance

- Restaging of **Colorectal Carcinoma** with suspected residual, metastatic or recurrent disease
- Restaging of metastatic **Melanoma** with potentially resectable disease
- Restaging of **Ovarian Cancer** with clinical/structural suspicion of recurrence
- Restaging of **Head & Neck Cancer** with clinical/structural suspicion of recurrence
- Restaging of **High grade Non Hodgkin's Lymphoma or Hodgkin's Lymphoma** during or within 3 months of completing first line treatment
- Restaging of confirmed recurrence of **High grade Non Hodgkin's or Hodgkin's Lymphoma**
- Restaging of **Lymphoma (Non Hodgkin's or Hodgkin's)** prior to stem cell transplantation
- Restaging of suspected residual/recurrent **Sarcoma**
- Restaging of confirmed recurrent **Cervical Cancer**
- Restaging of suspected residual/recurrent **Primary Brain Tumour** post therapy
- Restaging of suspected residual/recurrent **Sarcoma**
- Other (Non Funded Clinical Indication)**

* Please refer to note at top of page

Please Specify _____

Stage by Clinical and/or Investigation Findings Performed Up to Time of Referral

Stage _____

Based on;

- Clinical examination
- Pathology/Surgery
- CT/MRI/US (circle)
- Other _____

What would your management plan be if PET were unavailable#;

- Surgery
- Radical radiotherapy
- Radical chemoradiation
- Radical chemoradiation -> Surgery
- Neoadjuvant chemotherapy-> Surgery
- Systemic chemotherapy
- Palliative radiotherapy
- Invasive biopsy
- Observation
- Other _____

Management Plan intent

- Curative or Palliative

This is the final page of the referral – Not for scanning into medical record