TheAlfred

Alfred Hospital, Commercial Rd Melbourne VIC Australia 3004
Nuclear Medicine Department
Level 1 First Floor East Block

Phone:+61 3 9076 2432 Fax: +61 3 9076 2599

SPECT & PET Cognitive Decline Referral Form

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 intstructions _____

Referring Consultant Specialist

*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

Test Required (Please Tick) ☐ SPECT Brain ☐ PET Brain

Pre-Scan Diagnosis (Tick one or more)	Possible	Probable	Investigations Performed	Clinical Notes
Normal	☐	☐	Clinical Evaluation ☐	
Depression / Anxiety	☐	☐	Neuropsychologist ☐	
Minimal Cognitive Impairment (MCI)	☐	☐	CT ☐	
Alzheimer's disease (AD)	☐	☐	MRI ☐	
Front-temporal Dementia (FTD)	☐	☐	Routine Blood Screen ☐	
Diffuse Lewy Body (DLB)	☐	☐	Other ☐	
Vascular Dementia	☐	☐		
Mixed AD and Vascular Dementia	☐	☐		
Other	☐	☐		

ADDITIONAL NOTES:

Planned Imaging

CT/MRI BOOKED DATE:_____

OTHER BOOKED DATE:_____

Not for scanning into medical record