theAlfred

Alfred Hospital, 55 Commercial Rd Melbourne VIC Australia 3004
Department of Nuclear Medicine & PET
Level 1 First Floor East Block

Phone:+61 3 9076 2432 Fax: +61 3 9076 2599
Email: nmedbookings@alfred.org.au

FDG PET Cognitive Decline Referral Form

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

*PET scans must be specialist referred

Specialist Name _____ **Specialist Provider No:** _____

Phone contact: _____ **Signature:** _____

Please specify address where DVD & reports are to be sent: _____

_____

Fax (required to ensure report delivery):** _____ **Date of Referral** _____

Preferred timeframe for the PET to be performed: _____

Indication for FDG PET brain: (please tick one box)

☐ **Assessment for possible Alzheimer's Disease**
i.e. MBS item number 61560, max 3 rebatable studies per lifetime

☐ **Other (Unfunded)**
N.B. an out-of-pocket fee may apply

Brain FDG PET or SPECT claimed within last 12 months: Yes / No
If yes, date: _____

Clinical Notes:

Pre-Scan Diagnosis (Tick one or more)	Possible	Probable	Investigations Performed (Please attach result)
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	☐	☐	
Other	☐	☐	

Planned Imaging

CT/MRI BOOKED

DATE & LOCATION: _____

OTHER BOOKED

DATE & LOCATION: _____

Not for scanning into medical record