# PET/CT REQUEST

Paul Strickland Scanner Centre at Mount Vernon Hospital, Northwood, Middx HA6 2RN
Tel: 01923 886 311 Fax: 01923 886 313 email:psscpetct.enh-tr@nhs.net

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|---|---|
| **Research Only** Trial Name+Trial No .....<br>Patient Trial No. ....., Baseline ☐ , Week ..... | Standard of Care ☐ |

**ALL AREAS TO BE COMPLETED BY THE REFERRER, who must also sign and date.**
**Please note: We do not have nursing cover and cannot offer sedation.**

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| Title: Mr/Mrs/Miss/Ms/Other:<br>Surname: | NHS ☐ Private Patient ☐<br>Research ☐ Medico-Legal ☐ |
| First Name:<br>DoB: Sex: M ☐ F ☐ Other ☐ | Outpatient ☐ Ward:<br>Inpatient ☐ |
| Address:<br><br>Postcode: | **Patient transport:**<br>Own Transport ☐ Other Transport* ☐<br>* **Must** be arranged by referrer<br>**Patient mobility:**<br>Walking ☐ Chair ☐ Trolley ☐ Mobility Aid ☐<br>**Consent:** Does the patient have capacity to consent?<br>YES ☐ NO ☐<br>**If NO a form 4 must be completed and must accompany the patient.** |
| NHS No:<br>Hospital No: | Any possibility the patient could be pregnant?<br>YES ☐ NO ☐ Or Breastfeeding ☐ |
| Daytime telephone no:<br>Mobile telephone no: | **Medical needs:**<br>Does the patient have:- |
| **Communication:**<br>Is the patient fluent in English? YES ☐ NO ☐<br>If NO, specify preferred language:<br>.....<br>English speaking contact –<br>Name: .....<br>Contact number: .....<br>Does the patient have a visual or auditory or cognitive impairment? YES ☐ NO ☐<br>If YES please specify: ..... | • Diabetes? YES ☐ NO ☐<br>• An infection? YES ☐ NO ☐<br>• Poor venous access? YES ☐ NO ☐<br>• Claustrophobia? YES ☐ NO ☐<br>• Learning diff./ Dementia? YES ☐ NO ☐<br><br>Can the patient lie flat for 30 minutes? YES ☐ NO ☐<br>Further details if relevant<br>……...<br>**Accessible information required?** YES ☐ NO ☐ |

**Type of scan:**
*Tracer:* FDG ☐ Choline ☐ Other (specify): .....
*Anatomical area(s) of interest*: .....

Clinical Details & Provisional Diagnosis (If malignancy type and site):
(*Please state the clinical question that requires an answer*):

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|---|---|---|
| Previous RT/Chemo (date): | Surgery or biopsy Performed (date): | Date report required: |

Previous Scan/Date & Place: ***Required for comparison***
CT: MRI: PET:

| | |
|---|---|
| Referring Consultant: ……. | Speciality: ……... |
| Referrer's signature……. | Referring Hospital: …… |
| Name (print): …… | Telephone/Bleep Number: …….. |
| Status:…….. | GMC Number……. |
| Other- specify…….... | **Date of request:** …….. |