



**PACIFIC RADIOLOGY
PET/CT IMAGING REQUEST FORM - ONCOLOGY**

**PLEASE COMPLETE BOTH SIDES, ENSURE FORM IS SIGNED BY THE REFERRING CONSULTANT
FAX COMPLETED REQUEST TO 04 978 5501. FOR ALL ENQUIRIES PHONE 04 978 5535.**

Date results required by:	PATIENT IDENTIFICATION DETAILS OR STICKER
Reason if <u>URGENT</u> request:	
PATIENT INFORMATION <input type="checkbox"/> Patient is an inpatient at: <input type="checkbox"/> Diabetic? No / IDDM / NIDDM <input type="checkbox"/> Is patient claustrophobic? Yes / No Serum Creatinine: _____ Height: _____ cm Weight: _____ kg	
<i>NHI number:</i> <i>Surname:</i> <i>First name:</i> <i>Address:</i> <i>Phone numbers:</i> <i>Date of birth:</i> <i>Ethnicity: Maori NZ European /Other Pacific Peoples</i>	

REFERRING CONSULTANT / SPECIALIST

Name:	Referral Date:
Signature:	
Address:	Phone contact:
	Fax (if required):

ADDITIONAL REPORTS REQUIRED:

Name:	Practice/Dept:	Fax:
Name:	Practice/Dept:	Fax:

CLINICAL INFORMATION

Primary site of disease:	Histology / Pathology:
Date of Last Radiotherapy: ...dd.../...mm.../...yr...	Region:
Date of Last Chemotherapy: ...dd.../...mm.../...yr...	Which cycle:
Date of Next Chemotherapy: ...dd.../...mm.../...yr...	

FUNDING Private Medical Insurance DHB (please see bottom of page two)

RECENT CORRELATIVE IMAGING <input type="checkbox"/> CT Date: Provider/Where: <input type="checkbox"/> MRI Date: Provider/Where: <input type="checkbox"/> Other Date: Provider/Where:	RELEVANT FINDINGS
--	--

FOR VIEWING OF PRIOR IMAGING ELECTRONIC TRANSFER TO PRL PACS or VIA CD IS PREFERRED OPTION



Please select the appropriate clinical indication below and complete column appropriate to your selection.

Staging/Diagnosis	Restaging/Surveillance
<p><u>National Clinical Indications</u></p> <p><input type="checkbox"/> Isolated pulmonary nodules (SPN) not amenable to FNA or which have failed pathological characterisation</p> <p><input type="checkbox"/> Staging NSCLC (LUNG CANCER) prior to surgery or radiotherapy with curative intent</p> <p><input type="checkbox"/> Staging of early stage low grade Non Hodgkin's LYMPHOMA</p> <p><input type="checkbox"/> Staging of Hodgkin's Disease</p> <p><input type="checkbox"/> Staging of metastatic squamous carcinoma in cervical lymph nodes from Unknown Primary (UKP)</p> <p><input type="checkbox"/> Staging of locally advanced OESOPHAGEAL cancer for preoperative chemotherapy/radiotherapy</p> <p><input type="checkbox"/> Preoperative evaluation in patients considered for surgical resection of apparent limited disease from MALIGNANT MELANOMA</p> <p><u>Additional Clinical Indications</u></p> <p><input type="checkbox"/> BRAIN – primary tumour grading/biopsy guidance</p> <p><input type="checkbox"/> CERVICAL cancer staging prior to radiotherapy</p> <p><input type="checkbox"/> Staging of newly diagnosed GASTRIC cancer being considered for surgery</p> <p><input type="checkbox"/> Staging of newly diagnosed HEAD & NECK cancer</p> <p><input type="checkbox"/> Identification of biopsy site for SARCOMA</p> <p><input type="checkbox"/> Staging of SARCOMA</p> <p><input type="checkbox"/> Solitary Pulmonary Nodule (SPN)</p> <p><input type="checkbox"/> Other (please specify)</p> <hr/>	<p><u>National Clinical Indications</u></p> <p><input type="checkbox"/> Preop evaluation for patients considered for resection of hepatic/lung metastases of COLORECTAL carcinoma (CRC)</p> <p><input type="checkbox"/> Evaluation of residual structural abnormality on diagnostic imaging in patients who are currently symptomatic following treatments for COLORECTAL carcinoma (CRC)</p> <p><input type="checkbox"/> Restaging of residual mass after treatment for Non Hodgkin's LYMPHOMA following definitive treatment</p> <p><input type="checkbox"/> Restaging of residual neck masses in HEAD & NECK cancers following RT/Chemotherapy</p> <p><u>Additional Clinical Indications</u></p> <p><input type="checkbox"/> BRAIN – primary tumour restaging. Recurrence or radiation necrosis</p> <p><input type="checkbox"/> Restaging of suspected recurrent or residual Hodgkin's Disease</p> <p><input type="checkbox"/> Restaging of OVARIAN cancer</p> <p><input type="checkbox"/> Preoperative evaluation in patients considered for surgical resection of apparent limited disease from MALIGNANT MELANOMA</p> <p><input type="checkbox"/> Restaging of SARCOMA following definitive therapy</p> <p><input type="checkbox"/> Other (please specify)</p> <hr/>

For DHB Funded PET/CT scans:- Variance / exceptions basis indication

If the request is for a patient that does not meet the nationally approved clinical indications for PET scan please complete the right column below

Cancer Type	
Clinical Indication/Reason for imaging	

Please forward to your DHB any supporting information (e.g. clinical multidisciplinary meeting reports or journal articles)

To be completed by the specialist authorising the PET/CT scan request for the DHB

Authorising specialist signature	
Authorising specialist name	
DHB	
Date approved	

