



## MATER **PET/CT** CENTRE

*A public/private partnership between  
Mater Misericordiae University Hospital and Mater Private Hospital*

*ECCLES STREET / DUBLIN 7 / IRELAND  
TEL + 353 1 803 4970  
FAX + 353 1 803 4989  
EMAIL [materpetct@materprivate.ie](mailto:materpetct@materprivate.ie)*

### **ESB Prior Approval Form**

Please find attached an ESB prior approval form. Please make sure it is completed in full and attach copies of all relevant results.

When complete, please **fax or e-mail** the form to 01-8034989 or [materpetct@materprivate.ie](mailto:materpetct@materprivate.ie). This form will then be submitted immediately to ESB and the patient will be contacted with an appointment once we have received prior approval. Please be aware that sending back an incomplete form can delay the patient's appointment, so kindly make sure all sections are completed.

Prior to a PET/CT scan, the patient will need one day to prepare for the scan (by following a set diet) so please make sure and include contact details for the patient.

If you have any other queries, please do not hesitate to contact the undersigned.

Kind regards,

Bernie/Barbara  
**PET/CT Secretary**  
**Tel: 8034970**  
**Fax: 8034989**  
**Email: [materpetct@materprivate.ie](mailto:materpetct@materprivate.ie)**



**ESB STAFF MEDICAL PROVIDENT FUND**

**MPF Per-Authorisation  
of Positron Emission Tomography (PET)**

To: **Claims Manager**  
Medical Provident Fund  
27 Lower Fitzwilliam Street  
Dublin 2

From \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fax : 01-702 6788

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Staff or Membership No. \_\_\_\_\_

Type of PET Scan proposed: \_\_\_\_\_

Proposed Date of PET Scan: \_\_\_\_\_ Cost of Scan: \_\_\_\_\_

Condition requiring PET Scan: \_\_\_\_\_

Date of Onset of Symptoms requiring investigation: \_\_\_\_\_

Previous History and Treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous Investigations/scans and their results: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Clinical reasons why a PET Scan is indicated in preference to other diagnostic techniques: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How will a PET Scan affect the treatment plan: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MPF requires all of the above questions to be answered in full to enable benefit to be confirmed. If the above information is not provided, MPF will be unable to allow benefit towards a PET Scan.

I confirm that the proposed PET Scan is an integral part of a course of treatment which is being undertaken entirely as a private patient.

Name of Consultant: \_\_\_\_\_ Signature: \_\_\_\_\_