PET/CT REFERRAL FORM

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

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Today's Date: _____

Order Number: _____
(Finance Dept MMH: ext. 5022 / # 2179 or 2047/2205 / 4193)

Date PET/CT Required: _____

Patient Details:

Patient's Name: _____

DOB: _____ MRN: _____

Address: _____

Home Phone: _____ Mobile: _____

Inpatient:

Ward Name: _____

Ward Phone No: _____ Ward Fax No: _____

Referring Consultant:

Consultant _____ Consultant's signature: _____

Referring Hospital: _____

Phone: _____ Fax Number for Report: _____

Address for Results: _____

Clinical Information and History:

Primary Condition: _____

Surgeries: **Yes / No** Date of surgery: _____

Biopsies: **Yes / No** Date of biopsy: _____

Chemotherapy: **Yes / No** Date of last Chemo: _____

Radiotherapy: **Yes / No** Date of last radiotherapy: _____

Last creatinine result _____ Date of creatinine result_____

Last urea result_____ Date of urea result_____

When and where was patient's last CT scan? _____

Is there any CT scan planned in the next month? _____

Clinical Background (PLEASE GIVE AS MUCH INFORMATION AS POSSIBLE AS THIS ASSISTS WHEN REPORTING):

_____

_____

_____

_____

_____

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_____

Please arrange for relevant CD's of CT, MRI etc to be delivered to the PET/CT Centre prior to scan

Signed: _____ Bleep/Mobile: _____