PRINT

PET/CT Imaging Request Form

NUCLEAR MEDICINE & PET
LIVERPOOL HOSPITAL

SYDNEY SOUTH WEST AREA HEALTH SERVICE
NSW HEALTH

DR JOHN CHU AND ASSOCIATES ***1 ELIZABETH ST, LIVERPOOL NSW 2170***
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Patient Identification

Name: _____ DOB: ___/___/____ MRN: _____
Address: _____
Phone:(H): _____ (W): _____ (M): _____
Weight (kg): _____ NIDDM/IDDM: _____ Inpatient: ☐ Outpatient ☐.

❑ Urgent (<7 days) Reason: _____ ❑ 7-14 days ❑ By ___/___/____

Clinical Indication

Primary Site of Disease: _____
Histology/Pathology: _____ Pre PET stage: T ☐ N ☐ M ☐

_____

_____

_____

Surgery Type: _____ Most recent: ____/____/____
Radiotherapy Region: _____ Last: ____/____/____ Next: ____/____/____
Chemotherapy: _____ Last: ____/____/____ Next: ____/____/____

Indications for PET (Tick Only One)

❑ ***Characterisation of SOLITARY PULMONARY NODULES***
Where the lesion is considered unsuitable for transthoracic fine needle aspiration biopsy, or for which an attempt at pathological characterisation has failed (61523/61526).

❑ ***Primary staging of proven NON-SMALL CELL LUNG CANCER***
Where curative surgery or radiotherapy is planned (61529/61532).

❑ ***Suspected PRIMARY BRAIN TUMOUR***
To guide surgical biopsy of the lesion and to assist in treatment planning (61535).

❑ ***RESIDUAL structural brain lesion based on anatomical imaging findings, after definitive therapy for GLIOMA.*** (61538)

❑ ***REFRACTORY EPILEPSY which is being evaluated for surgery***
Where results of standard assessment are inconclusive for localisation of the epileptogenic focus (61559).

❑ ***Suspected RECURRENT COLORECTAL CARCINOMA***
In a symptomatic patient for the evaluation of a residual structural lesion, after definitive therapy (61541/61544).

❑ ***Apparently isolated liver or pulmonary metastases following previous therapy for COLORECTAL CARCINOMA***
Where surgical resection is planned (61547/61550).

❑ ***Apparently limited metastatic disease from MALIGNANT MELANOMA***
Where surgical resection is planned (61553/61556).

❑ ***Suspected RECURRENT EPITHELIAL OVARIAN CARCINOMA***
Based on equivocal anatomical imaging findings or an elevation of CA-125 (61565/61568).

❑ ***Primary staging of proven UTERINE CERVICAL CARCINOMA***
Prior to planned radical radiation therapy or combined modality therapy (61571/61574).

❑ ***Staging of proven OESOPHAGEAL CARCINOMA***
Where curative surgery or chemoradiation is planned (61577/61580).

❑ ***Staging of proven GASTRIC CARCINOMA***
Where curative surgery is planned (61583/61586).

❑ ***Primary staging of CARCINOMA OF THE HEAD & NECK.*** (61598)

❑ ***Suspected residual or recurrent HEAD & NECK CANCER.*** (61604)

❑ ***METASTATIC SCC involving cervical nodes***
From an unknown primary site (61610/61613).

❑ ***Staging of newly diagnosed or previously untreated LYMPHOMA.***
(61616/61619)

❑ ***Residual mass after treatment of LYMPHOMA.*** (61622/61625)

❑ ***Suspected recurrent or residual LYMPHOMA.*** (61628/61631)

❑ ***Suspected bone or soft tissue SARCOMA***
To guide biopsy where structural imaging suggests lesional heterogeneity (61634/61637).

❑ ***Staging of biopsy-proven bone or soft tissue SARCOMA***
Being considered for resection of the primary or limited metastatic disease (61640/61643).

❑ ***Suspected residual or recurrent SARCOMA***
On structural imaging after definitive therapy (61646/61649).

❑ ***MYOCARDIAL VIABILITY***
Where revascularisation surgery is being considered and standard myocardial viability tests are negative or equivocal for ischaemia (61562).

❑ ***UNFUNDED (specify)*** _____

- ❑ The patient is aware there will be a charge and is agreeable to this
- ❑ The referring institution is funding the study

  Cost Code _____ Approved by _____
- ❑ Please consider performing this study on compassionate grounds

Referring Consultant / Specialist*: _____ **Provider #:** _____
Phone: _____ Fax: _____ Signature: _____
Address: _____

All sections must be completed and the patient must be Specialist referred. Incomplete referrals will not be booked.

Referral ID Number (Office Use Only): _____