



MR 100B



Western Private Hospital

PET Centre
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Referral forms may be
 downloaded from:
[www.westernprivatehospital.com.au/
 clinical-services/pet-centre](http://www.westernprivatehospital.com.au/clinical-services/pet-centre)

PET/CT IMAGING REQUEST FORM - ONCOLOGY

Please complete both sides & ensure form is signed by the referring Consultant or MO on their behalf

Date results required by:/...../..... or circle below

< 3 days 1 week 2-3 weeks months

Reason for URGENT scan:

Inpatient	N	Y	Location
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Diabetes	N	Y	Type
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Claustrophobic	N	Y	
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Interpreter required	N	Y	Language
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Radiotherapy Planning PET	N	Y	Contact
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Clinical Trial	N	Y	Trial Code
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Clinic Trial Contact:

Patient Identification Details or Label
 (Three or more patient identifiers)

WPH UR Number

Surname

First Name

Date of Birth/...../..... Male / Female

Address

.....

Email:

Home/Work Phone:

Mobile Phone: (Preferred)

Tracer
(please circle)

¹⁸F-FDG

¹⁸F-PSR

(prostate specific)

⁶⁸Ga-PSMA

⁶⁸Ga DOTATATE

PET/CT Clinical Indication

Primary site of Disease:

Histology / Pathology:

Key Clinical Question:

Relevant History and Findings:

Recent Surgery (please state)

Recent/Ongoing Chemotherapy Radiotherapy	Type	Cycle Length	Date of Last Treatment	Date of Next Treatment
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**Additional to the PET/CT, a full diagnostic CT
 with Oral and or IV contrast is required**

Yes

No

RECENT CORRELATIVE IMAGING

CT	Date/...../.....	Where
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Exam region for Diagnostic CT	MRI	Date/...../.....	Where
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eGFR:	Creat	Date/...../.....	Other	Date/...../.....	Where
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Referring Specialist Details ***Medicare requires that to be reimbursable, PET/CT scan must be specialist referred**

Specialist Name	Email
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Provider Number	Address
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Healthlink ID	Phone	Fax
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Your Name	Specialist / MO Signature	Date
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Copies of report to

At

BINDING MARGIN - DO NOT WRITE IN THIS AREA

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PET/CT IMAGING REQUEST FORM - ONCOLOGY MR 100B



MFR 100B

Patient Name

INCOMPLETE REFERRALS CANNOT BE BOOKED – Please select the appropriate clinical indication below**PET/CT Medicare Eligible Clinical Indications***Medicare rebates are available to patients referred by a specialist if the clinical indications meet the published MBS criteria summarised below.* Diagnosis / Staging Left column **ONLY** Restaging / Therapeutic Monitoring Right column **ONLY**

<input type="checkbox"/>	Refractory EPILEPSY being evaluated for surgery	<input type="checkbox"/>	Suspected residual or recurrent malignant BRAIN TUMOUR on CT/MRI after definitive therapy or during ongoing chemotherapy
<input type="checkbox"/>	Solitary pulmonary nodule (Unsuitable/failed Bx)	<input type="checkbox"/>	COLORECTAL carcinoma suitable for active therapy
<input type="checkbox"/>	Staging of newly diagnosed NSCLC being considered for curative surgery or RT	<input type="checkbox"/>	MELANOMA suitable for active therapy
<input type="checkbox"/>	CERVICAL cancer (> FIGO IB2) prior to RT or combined therapy with curative intent	<input type="checkbox"/>	OVARIAN cancer suitable for active therapy
<input type="checkbox"/>	Staging of OESOPHAGEAL or GOJ cancer being considered for active therapy.	<input type="checkbox"/>	CERVICAL cancer with confirmed local recurrence suitable for salvage pelvic CRT or pelvic exenteration
<input type="checkbox"/>	Staging newly diagnosed HEAD & NECK cancer	<input type="checkbox"/>	Suspected residual HEAD & NECK cancer after definitive treatment suitable for active therapy.
<input type="checkbox"/>	Evaluation of METASTATIC SCC (unknown primary) involving cervical nodes.	<input type="checkbox"/>	Response assessment during or within 3 months of first line treatment for HODGKIN'S or AGGRESSIVE NHL
<input type="checkbox"/>	Staging of newly diagnosed NHL if Stage 1 or 1A and planned for definitive RT with curative intent	<input type="checkbox"/>	Recurrence of HODGKIN'S or AGGRESSIVE NHL
<input type="checkbox"/>	Staging of newly diagnosed or previously untreated HODGKIN'S or AGGRESSIVE NHL	<input type="checkbox"/>	Response assessment of HODGKIN'S or AGGRESSIVE NHL to second line chemotherapy if stem cell transplantation being considered
<input type="checkbox"/>	Staging of potentially curable SARCOMA (except GIST)	<input type="checkbox"/>	Suspected residual or recurrent SARCOMA (except GIST) after initial course definitive therapy
Stage by clinical and/or investigation findings performed up to the time of referral		Disease status based on assessment up to time of referral	
T	Site	No evidence of disease	
N	Location	Local	Site
M	Site(s)	Loco-regional	Site
Or	Stage	Systemic disease	Site(s)
		Equivocal	Location

Stage / Disease Status based on (please tick)
 Clinical Exam
 Histology / Cytology
 CT / MRI / US
 Other
What would your management plan be WITHOUT PET?

<input type="checkbox"/> Invasive biopsy	<input type="checkbox"/> Surgery	<input type="checkbox"/> Systemic chemo	<input type="checkbox"/> Salvage Curative surgery
<input type="checkbox"/> Radical RT	<input type="checkbox"/> Palliative RT	<input type="checkbox"/> Palliative surgery	<input type="checkbox"/> Expectant Palliative
<input type="checkbox"/> Radical ChemoRT	<input type="checkbox"/> Radical Chemo RT then surgery	<input type="checkbox"/> Palliative RT	<input type="checkbox"/> Observation
<input type="checkbox"/> Neoadj Chemo then Sx	<input type="checkbox"/> Other	<input type="checkbox"/> Combined modality. Specify	

PET/CT Medicare In-eligible Clinical Indication

Patients referred for unfunded PET scan indications will be charged. Pension and concession card holder rates will apply

Clinical Indication

The cost of the scan will be met by	Referring hospital	<input type="checkbox"/>	Patient	<input type="checkbox"/>
	Veteran's Affairs	<input type="checkbox"/>	SHINE/OMHIP Program (⁶⁸ Ga DOTATATE only)	<input type="checkbox"/>

OFFICE USE ONLY

EXAM CODE			CHECKED BY NMP				DATE		
SCAN LENGTH	BRAIN only	Vertex	Base of Brain	Neck	Mid-thigh	Distal Primary	Arms	U D	
INTERVENTION			DIABETES		GATING	Region	Lung	Liver	Segment
Neg Oral contrast	Propranolol	Metformin	Y / N						
Saline +/- Lasix	Buscopan	Stop date:							

BINDING MARGIN – DO NOT WRITE IN THIS AREA