MR 100B

PET Centre
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Western Private Hospital

PET/CT IMAGING REQUEST FORM - ONCOLOGY

Print

Referral forms may be downloaded from: www.westernprivatehospital.com.au/clinical-services/pet-centre

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		Location
Diabetes		Type
Claustrophobic		
Interpreter required		Language
Radiotherapy Planning PET		Contact
Clinical Trial		Trial Code
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)*	^{18}F-FDG ☐	^{18}F-PSR ☐ *(prostate specific)*	^{68}Ga-PSMA ☐	^{68}Ga DOTATATE ☐

PET/CT Clinical Indication

Primary site of Disease:

Histology / Pathology:

Key Clinical Question:

Relevant History and Findings:

Recent Surgery (please state)

Recent/Ongoing	Type	Cycle Length	Date of Last Treatment	Date of Next Treatment
Chemotherapy				
Radiotherapy				

Additional to the PET/CT, a full diagnostic CT with Oral and or IV contrast is required ☐

Exam region for Diagnostic CT

eGFR: Creat Date ...../...../.....

RECENT CORRELATIVE IMAGING

CT	Date ...../...../.....	Where
MRI	Date ...../...../.....	Where
Other	Date ...../...../.....	Where

Referring Specialist Details ***Medicare requires that to be reimbursable, PET/CT scan must be specialist referred***

Specialist Name	Email	
Provider Number	Address	
Healthlink ID	Phone Fax	
Your Name	Specialist / MO Signature	Date

Copies of report to

At

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BINDING MARGIN – DO NOT WRITE IN THIS AREA

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**	
◯	Refractory **EPILEPSY** being evaluated for surgery	◯	Suspected residual or recurrent malignant **BRAIN TUMOUR** on CT/MRI after definitive therapy or during ongoing chemotherapy
◯	**Solitary pulmonary nodule** (Unsuitable/failed Bx)	◯	**COLORECTAL** carcinoma suitable for active therapy
◯	Staging of newly diagnosed **NSCLC** being considered for curative surgery or RT	◯	**MELANOMA** suitable for active therapy
◯	**CERVICAL** cancer (> FIGO IB2) prior to RT or combined therapy with curative intent	◯	**OVARIAN** cancer suitable for active therapy
◯	Staging of **OESOPHAGEAL** or **GOJ** cancer being considered for active therapy.	◯	**CERVICAL** cancer with confirmed local recurrence suitable for salvage pelvic CRT or pelvic exenteration
◯	Staging newly diagnosed **HEAD & NECK** cancer	◯	Suspected residual **HEAD & NECK** cancer after definitive treatment suitable for active therapy.
◯	Evaluation of **METASTATIC SCC (unknown primary)** involving cervical nodes.	◯	Response assessment during or within 3 months of first line treatment for **HODGKIN'S** or **AGGRESSIVE NHL**
◯	Staging of newly diagnosed **NHL** if Stage 1 or 1A and planned for definitive RT with curative intent	◯	Recurrence of **HODGKIN'S** or **AGGRESSIVE NHL**
◯	Staging of newly diagnosed or previously untreated **HODGKIN'S or AGRESSIVE NHL**	◯	Response assessment of **HODGKIN'S** or **AGGRESSIVE NHL** to second line chemotherapy if stem cell transplantation being considered
◯	Staging of potentially curable **SARCOMA** (except GIST)	◯	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?

☐ Invasive biopsy	☐ Surgery	☐ Systemic chemo	☐ Salvage Curative surgery
☐ Radical RT	☐ Palliative RT	☐ Palliative surgery	☐ Expectant Palliative
☐ Radical ChemoRT	☐ Radical Chemo RT then surgery	☐ Palliative RT	☐ Observation
☐ Neoadj Chemo then Sx	☐ Other	☐ 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		Veteran's Affairs ◯		Referring hospital ◯		Patient ◯	
The cost of the scan will be partly reimbursed by (68Ga DOTATATE only)		SHINE/OMHIP ◯		Assist BEYOND ◯			

☐

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				U		
Saline +/- Lasix	Buscopan	Stop date:				M		
						L		

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