



MR 100B



Western Private Hospital

PET Centre
 Western Private Hospital
 Ground Floor, 44 Eleanor Street
 Footscray, VIC 3013
 P: +61 3 9304 7360
 F: +91 3 9304 7361
 E: petcentre@westernprivate.com.au

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				Patient Identification Details or Label (Three or more patient identifiers)			
< 3 days	1 week	2-3 weeks months				
Reason for URGENT scan:				WPH UR Number			
Inpatient				Surname			
Diabetes				First Name			
Claustrophobic				Date of Birth Male / Female			
Interpreter required				Address			
Radiotherapy Planning PET						
Clinical Trial				Email:			
Clinic Trial Contact:				Home/Work Phone:			
				Mobile Phone: (Preferred)			

Tracer <i>(please circle)</i>	¹⁸F-FDG	¹⁸F-PSR <i>(prostate specific)</i>	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

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
Exam region for Diagnostic CT			MRI	Date	Where
eGFR:	Creat	Date	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					

BINDING MARGIN - DO NOT WRITE IN THIS AREA

WESTPH_MR100B_11/16 ©2016. BARKER & BARKER MEDIA Pty Ltd

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 first line treatment for HODGKIN or NON-HODGKIN LYMPHOMA
<input type="checkbox"/> Staging of newly diagnosed or previously untreated HODGKIN or NON-HODGKIN LYMPHOMA	<input type="checkbox"/> Recurrence of HODGKIN or NON-HODGKIN LYMPHOMA
<input type="checkbox"/> Staging of potentially curable SARCOMA (except GIST)	<input type="checkbox"/> Response assessment of HODGKIN or NON-HODGKIN LYMPHOMA to second line chemotherapy if haemopoietic stem cell transplantation being considered
<input type="checkbox"/> (COMING SOON - Diagnosis/Staging of NEUROENDOCRINE cancer with ⁶⁸Ga-DOTATATE)	<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	Veteran's Affairs	Referring hospital	<input type="checkbox"/>	Patient	<input type="checkbox"/>
	Trial	<input type="checkbox"/>	Unit Contact		

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