

## PET Imaging Request Form – Oncology

**PLEASE COMPLETE BOTH SIDES & ENSURE FORM IS SIGNED BY THE REFERRING CONSULTANT**

<p>Date results required by: <small>(Please indicate date or circle below)</small></p> <p><b>&lt; 3 days    1 week    2-3weeks    &gt; 1 month</b></p> <p>Reason for <b>URGENT</b> scan:</p> <hr/> <p><input type="checkbox"/> Inpatient?      Where?</p> <p><input type="checkbox"/> Diabetic?      IDDM / NIDDM</p> <p><input type="checkbox"/> Claustrophobic?</p> <p><input type="checkbox"/> <b>PET/CT to be used for Radiotherapy Dosimetry?</b></p> <p><input type="checkbox"/> <b>Clinical Trial?</b></p> <p>Code: <span style="border: 1px solid black; padding: 2px 10px; margin-left: 20px;">Tracer</span></p> <p>Research Nurse:</p>	<p><b>PATIENT IDENTIFICATION DETAILS or STICKER</b></p> <p>PMCC UR Number:</p> <p>Surname:</p> <p>First name:</p> <p>Date of birth:</p> <p>Address:</p> <p>Home Phone:</p> <p>Mobile Phone:</p> <p>Work Phone:</p>																								
<p><b>CLINICAL INDICATION</b></p> <p><b>Primary Site of Disease:</b> <span style="float: right;"><b>Histology / Pathology:</b></span></p> <p>Notes:</p>																									
<p><b>RECENT CORRELATIVE IMAGING</b></p> <p><input type="checkbox"/> <b>CT</b>    Date:      Where:</p> <p><input type="checkbox"/> <b>MRI</b>    Date:      Where:</p> <p><input type="checkbox"/> <b>Other</b>    Date:      Where:</p>	<p><b>RELEVANT FINDINGS</b></p>																								
<p><b>REFERRING CONSULTANT/SPECIALIST</b>      <i>* Medicare requires that to be reimbursable, PET scans must be <u>specialist referred</u></i></p> <p>Specialist Name: <span style="float: right;">Specialist Provider Number:</span></p> <p>Address: <span style="float: right;">Phone:</span></p> <p><span style="float: right;">Fax:</span></p> <p><b>Date:</b>      <b>Your Name:</b>      <b>Your Signature:</b></p> <p>Copies of report to:</p> <p>At:</p>																									
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;"><b>OFFICE USE ONLY</b></td> <td style="width:25%;">FILM BAG: PMCC / OUTSIDE / CD</td> <td style="width:25%;">M/C: YES / NO / PAY</td> <td style="width:25%;">DISC / STE / EITHER</td> </tr> <tr> <td style="text-align: center;">P#</td> <td style="text-align: center;">Status</td> <td style="text-align: center;">Hosp</td> <td style="text-align: center;">Loc</td> </tr> <tr> <td style="text-align: center;">Exam</td> <td style="text-align: center;">Account</td> <td style="text-align: center;">Inst. sent</td> <td style="text-align: center;">Appointment</td> </tr> <tr> <td style="border: 1px solid black; width: 50px; height: 30px;"></td> <td style="border: 1px solid black; width: 50px; height: 30px;"></td> <td style="border: 1px solid black; width: 50px; height: 30px;"></td> <td style="border: 1px solid black; width: 50px; height: 30px;"></td> </tr> <tr> <td style="border: 1px solid black; width: 50px; height: 30px;"></td> <td style="border: 1px solid black; width: 50px; height: 30px;"></td> <td style="border: 1px solid black; width: 50px; height: 30px;"></td> <td style="border: 1px solid black; width: 50px; height: 30px;"></td> </tr> <tr> <td style="border: 1px solid black; width: 50px; height: 30px;"></td> <td style="border: 1px solid black; width: 50px; height: 30px;"></td> <td style="border: 1px solid black; width: 50px; height: 30px;"></td> <td style="border: 1px solid black; width: 50px; height: 30px;"></td> </tr> </table> <p>Notes:</p> <p><b>INTERVENTIONS:</b>    SED      IDC      GA      NONE      <b>CHECKED BY NMP:</b></p> <p><b>SCAN LENGTH:</b>      Brain (ONLY)    Vertex      Base of Brain      Neck      Mid-thigh      Distal Primary      <b>Arms:</b>    U    D</p>		<b>OFFICE USE ONLY</b>	FILM BAG: PMCC / OUTSIDE / CD	M/C: YES / NO / PAY	DISC / STE / EITHER	P#	Status	Hosp	Loc	Exam	Account	Inst. sent	Appointment												
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Medicare rebates are available to private patients referred by a Specialist if the clinical indication meets the following criteria & the requisite information on this form is fully completed.

\* **Other Non-funded indications will attract a charge of \$800.00 or \$400.00 for Pension & Concession card holders. Overseas & Screening patients will attract a charge of \$1500.00 & are billed on the day of the scan.**

**INCOMPLETE REFERRALS WILL NOT BE BOOKED.**

Please Select the appropriate clinical indication below & complete column appropriate to your selection.

**Staging/Diagnosis**

- Solitary pulmonary nodule
- Staging of newly diagnosed NSCLC (**LUNG CANCER**) being considered for radical RT or surgery
- BRAIN** – primary tumour grading/biopsy guidance
- CERVICAL** cancer staging prior to radiotherapy
- Staging of newly diagnosed **OESOPHAGEAL** cancer being for radical RT or surgery
- Staging of newly diagnosed **GASTRIC** cancer being considered for surgery
- Staging of newly diagnosed **HEAD & NECK** cancer
- Evaluation of metastatic cervical nodes from **UKP**
- Staging of newly diagnosed **LYMPHOMA**
- Metastatic **MALIGNANT MELANOMA** with potentially-resectable disease/suitable for active therapy
- Identification of biopsy site for **SARCOMA**
- Staging of **SARCOMA**
- Other (Non-funded clinical indication)

\* Please refer to note at top of page

Please specify \_\_\_\_\_

**Stage by Clinical &/or Investigation Findings Performed Up to Time of Referral:**

- T-stage Site: \_\_\_\_\_
- N stage Location: \_\_\_\_\_
- M stage Site(s): \_\_\_\_\_
- Or Stage \_\_\_\_\_

**Based on:**

- Clinical examination
- Pathology/Surgery
- CT
- Other \_\_\_\_\_

**What would your management plan be if PET were unavailable:**

- Surgery
- Radical radiotherapy
- Radical chemoradiation
- Radical chemoradiation -> Surgery
- Neoadjuvant chemotherapy-> Surgery
- Systemic chemotherapy
- Palliative radiotherapy
- Invasive biopsy
- Observation
- Other \_\_\_\_\_

**Management Plan Intent:**

- Curative or  Palliative

**Restaging/Surveillance**

- Restaging of **COLORECTAL** carcinoma with suspected residual, metastatic or recurrent disease, suitable for active therapy.
- Restaging of **HEAD & NECK** cancer
- Restaging of **OVARIAN** cancer with suspected residual, metastatic or recurrent disease in patients suitable for active treatment.
- BRAIN** – primary tumour restaging. Recurrence or radiation necrosis.
- Metastatic **MALIGNANT MELANOMA** with potentially-resectable disease/suitable for active therapy.
- Evaluation of residual mass after treatment of **LYMPHOMA**
- Restaging of suspected recurrent or residual **LYMPHOMA**
- Restaging of **SARCOMA** following definitive therapy
- Other (Non-funded clinical indication)

\* Please to note at top of page

Please specify \_\_\_\_\_

**Disease Status Based on Assessment Performed Up to Time of Referral:**

- No evidence of disease
- Local recurrence Site: \_\_\_\_\_
- Loco-regional recurrence Site: \_\_\_\_\_
- Systemic disease Site(s): \_\_\_\_\_
- Equivocal Location: \_\_\_\_\_

**Based on:**

- Clinical examination
- Pathology/Surgery
- CT
- Other \_\_\_\_\_

**What would your management plan be if PET were unavailable:**

- Salvage curative surgery
- Palliative surgery (debulking etc)
- Radical radiotherapy
- Radical chemoradiation
- Combined modality. Specify \_\_\_\_\_
- Systemic chemotherapy
- Palliative radiotherapy
- Expectant palliative
- Invasive biopsy
- Observation
- Other \_\_\_\_\_

**Management Plan Intent:**

- Curative or  Palliative