PET-CT Imaging Request Form
National Cancer Institute

Please fill up the relevant information with a copy of pathology and relevant imaging results and fax the form to 03-83124377.
Appointment will be given once completed form is submitted.
Please call 03-83145501 for confirmation.

Patient's Name:		**Gender :**	**Ethnic group :**
I/C No :	**Date of Birth :**	**Age :**	**Contact No :**
Address :			
City/Town :	**Postcode :**	**State :**	

Appointment Date:
(to be filled by PET-CT staff)

Relevant medical history :

Diabetic?	☐ No	☐ Yes	(Medication):_____
Claustrophobic?	☐ No	☐ Yes	
Drug allergy?	☐ No	☐ Yes	(Medication):_____
Pregnant?	☐ No	☐ Yes	(LMP:_____)

Type of PET-CT study : ☐ **^{18}F-FDG** ☐ **^{68}Ga-DOTATOC**

Clinical Diagnosis:
(please specify stage of disease)

Primary site of disease :

Reason For PET/CT study :

Oncology
- □ Evaluation of unknown primary
- □ Evaluation of solitary pulmonary nodule
- □ Staging of newly diagnosed malignancy
- □ Restaging when clinical/structural suspicion of recurrence or rising trend of tumor marker
- □ Evaluation of post-treatment response
- □ Identification of biopsy site for cancer
- □ Surveillance

Neurology
- □ Evaluation of inter-ictal seizure focus
- □ Evaluation of dementia

Cardiology
- □ Evaluation cardiac viability

Infection / Inflammation
- □ Evaluation of pyrexia of unknown origin

□ **Other:**

Concise clinical summary:

Relevant Findings (please fill up all applied) :

☐ Clinical examination
Findings :

_____

_____

☐ Surgery / Histopathology (Date)
Findings :

_____

_____

☐ Imaging : CT / MRI / PET-CT (Date)
Findings :

_____

_____

☐ Others: (ie CEA / CA 125 / CgA / Ki-67) (Date)

Treatment? ☐ Yes ☐ No

☐ Surgery
(Date:_____, Site:

☐ Radiotherapy
(Date:_____, Site:

☐ Chemotherapy
(Date:_____, Regime:

Type of Appointment Required:

☐ **Urgent** ☐ **Normal** ☐ **Preferred Date**

Referring consultant / specialist:

Name :_____ **Signature & Official Stamp :**

_____

Title :_____ **Tel. No :**_____

Hospital : _____ **Fax. Add :** _____

Date of referral :_____ **Email Add :** _____

* Referring doctor may be called to clarify request.

Check list:

- ☐ Completed form with specialist signature & official stamp
- ☐ Pathology report
- ☐ Imaging (US, CT, MRI, NM imaging) report
- ☐ Contactable phone number (patient and referring doctor)
- ☐ Imaging film or CD for patient to bring along during appointment