PET/CT REQUEST

Paul Strickland Scanner Centre at Mount Vernon Hospital, Northwood, Middx HA6 2RN
Tel: 01923 886 311 Fax: 01923 886 313 email:psscpetct.enh-tr@nhs.net

Research Only Trial Name + Trial No ..... Patient Trial No. ....., Baseline ☐ , Week	Standard of Care ☐

ALL AREAS TO BE COMPLETED BY THE REFERRER, who must also sign and date.
Please note: We do not have nursing cover and cannot offer sedation.

Title: Mr/Mrs/Miss/Ms/Other: Surname:	NHS ☐ Private Patient ☐ Research ☐ Medico-Legal ☐
First Name: DoB: Sex: M ☐ F ☐ Other ☐	Outpatient ☐ Ward: Inpatient ☐
Address: Postcode:	**Patient transport:** Own Transport ☐ Other Transport* ☐ * **Must** be arranged by referrer **Patient mobility:** Walking ☐ Chair ☐ Trolley ☐ Mobility Aid ☐
GP surgery: GP name:	**Consent:** Does the patient have capacity to consent? YES ☐ NO ☐ **If NO a form 4 must be completed and must accompany the patient.**
NHS No: Hospital No:	Any possibility the patient could be pregnant? YES ☐ NO ☐ Or Breastfeeding ☐
Daytime telephone no: Mobile telephone no:	**Medical needs:** Does the patient have:-
Communication: Is the patient fluent in English? YES ☐ NO ☐ If NO, specify preferred language: ..... English speaking contact – Name: ..... Contact number: ..... Does the patient have a visual or auditory or cognitive impairment? YES ☐ NO ☐ If YES please specify:	• Diabetes? YES ☐ NO ☐ • An infection? YES ☐ NO ☐ • Poor venous access? YES ☐ NO ☐ • Claustrophobia? YES ☐ NO ☐ • Learning diff./ Dementia? YES ☐ NO ☐ Can the patient lie flat for 30 minutes? YES ☐ NO ☐ Further details if relevant ……... **Accessible information required?** YES ☐ NO ☐

Type of scan:
Tracer: FDG ☐ PSMA ☐ Choline ☐ Other (specify):.....
Anatomical area(s) of interest: .....

Clinical Details & Provisional Diagnosis (If malignancy, type and site):
(*Please state the clinical question that requires an answer*):

MDT/Clinic follow-up date:

Previous RT/Chemo (date):	Surgery or biopsy Performed (date):	Date report required:

Previous Scan/Date & Place: ***Required for comparison***
CT: MRI: PET:

Referring Consultant: …….	Speciality: ……...
Referrer's signature……	Referring Hospital: ……
Name (print): ……	Telephone/Bleep Number: ……..
Status:……...	GMC Number……
Other - specify……....	**Date of request:** ……..