PAUL STRICKLAND SCANNER CENTRE PET/CT REQUEST

Paul Strickland Scanner Centre, Mount Vernon Hospital, Rickmansworth Road, Northwood, HA6 2RN
Telephone: 01923 886311 Email: psscpetct.enh-tr@nhs.net

ALL AREAS MUST BE COMPLETED BY THE REFERRER – INCOMPLETE FORMS WILL CAUSE DELAYS

Title: Mr/Mrs/Miss/Ms/Dr/Other:

Surname:

First Name:

DoB: **Sex: M** ☐ **F** ☐

NHS Number:

Full address *(inc postcode)*

Patient contact numbers:

Email address:

Communication: Preferred language: English ☐ Other ☐
*If **OTHER**, specify preferred language:*
Please provide an English-speaking contact
Name:
Contact number::

GP name and address:

Patient Type: NHS ☐ **PRIVATE** ☐ **RESEARCH** ☐
(RESEARCH TRIAL NAME & NUMBER)

OUTPATIENT ☐ **INPATIENT** ☐

Referring Hospital

Name/Number of Ward if IP

PATIENT MOBILITY: WALKING ☐ **CHAIR** ☐ **TROLLEY** ☐

PATIENT TRANSPORT: ☐ **OWN** ☐ **HOSPITAL TRANSPORT***
*To be organised by referrer

CONSENT: Does the patient have capacity to consent? **Y** ☐ **N** ☐
*If **NO** – a form 4 must be provided prior to patient attending*

Could the patient be pregnant? Y ☐ **N** ☐ **NA** ☐

Is the patient breastfeeding? Y ☐ **N** ☐ **NA** ☐

Can patient lay flat and still for 30 minutes? Y ☐ **N** ☐

Previous RT/Chemo date:

Surgery/Biopsy:

Date report required:

Medical history:

Previous cancer diagnosis	Y ☐ N ☐		Learning difficulties	Y ☐ N ☐	
Type			Cognitive impairement	Y ☐ N ☐	
Diabetes	Y ☐ N ☐		Visual impairment	Y ☐ N ☐	
Current infection	Y ☐ N ☐		Auditory impairment	Y ☐ N ☐	
Poor venous access					
Claustrophobia	Y ☐ N ☐		Accessible info required	Y ☐ N ☐	

Radiopharmaceutical required *(failure to indicate tracer will cause delays)*
FDG ☐
PSMA ☐ **OTHER** ☐ *Please specify*

Previous imaging Y ☐ **N** ☐ (If **Y** - provide details)
Scan type?
Date & Location?

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

Referrer's Declaration:

- The correct patient details are given
- I have discussed the examination with the patient/guardian and informed them of the risk and benefit of radiation exposure.
- I have ensured that the patient is not pregnant.
- I have given sufficient clinical information for the request to be justified according to IR(ME)R 2017 (and amendments)
- I have considered the available guidelines (I-Refer and NICE Guidance) to ensure that this is the most appropriate imaging referral at the right time for the above-named patient.
- I will ensure the examination results are placed in the patients notes

Lead Consultant:
Name and grade of doctor completing this form:
(FY2 and above only or on our list of authorised non-medical referrer's)

GMC/RGN Registration Number:

Referrer's Signature

Contact details:

Date of request