

## 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

<b>Title: Mr/Mrs/Miss/Ms/Dr/Other:</b>		Patient Type: NHS    PRIVATE    RESEARCH (RESEARCH TRIAL NAME & NUMBER)																																			
Surname:		OUTPATIENT    INPATIENT																																			
First Name:		Referring Hospital																																			
DoB:	Sex: M    F	Name/Number of Ward if IP																																			
NHS Number:		PATIENT MOBILITY: WALKING    CHAIR    TROLLEY																																			
Full address (inc postcode)		PATIENT TRANSPORT:    OWN    HOSPITAL TRANSPORT* *To be organised by referrer																																			
		CONSENT: Does the patient have capacity to consent? Y    N <i>If NO – a form 4 must be provided prior to patient attending</i>																																			
Patient contact numbers:		Could the patient be pregnant? Y    N    NA																																			
		Is the patient breastfeeding? Y    N    NA																																			
Email address:		Can patient lay flat and still for 30 minutes? Y    N																																			
		Previous RT/Chemo date:																																			
Communication: Preferred language: English    Other <i>If OTHER, specify preferred language:</i> Please provide an English-speaking contact Name: Contact number::		Surgery/Biopsy:																																			
		Date report required:																																			
GP name and address:		<b>Medical history:</b>																																			
		<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Previous cancer diagnosis</td> <td style="width: 10%;">Y</td> <td style="width: 10%;">N</td> <td style="width: 30%;">Learning difficulties</td> <td style="width: 10%;">Y</td> <td style="width: 10%;">N</td> </tr> <tr> <td>Type</td> <td></td> <td></td> <td>Cognitive impairment</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Diabetes</td> <td>Y</td> <td>N</td> <td>Visual impairment</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Current infection</td> <td>Y</td> <td>N</td> <td>Auditory impairment</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Poor venous access</td> <td></td> <td></td> <td>Accessible info required</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Claustrophobia</td> <td>Y</td> <td>N</td> <td></td> <td></td> <td></td> </tr> </table>		Previous cancer diagnosis	Y	N	Learning difficulties	Y	N	Type			Cognitive impairment	Y	N	Diabetes	Y	N	Visual impairment	Y	N	Current infection	Y	N	Auditory impairment	Y	N	Poor venous access			Accessible info required	Y	N	Claustrophobia	Y	N	
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Claustrophobia	Y	N																																			
Radiopharmaceutical required (failure to indicate tracer will cause delays)		Previous imaging Y    N    (If Y - provide details)																																			
FDG <input type="checkbox"/>		Scan type?																																			
PSMA <input type="checkbox"/> OTHER <input type="checkbox"/> Please specify		Date & Location?																																			

Important: This form is not complete.

Please scroll down to the next page to fill in Clinical and Referrer details.

**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 :**