

PAUL STRICKLAND SCANNER CENTRE PET/CT REQUEST

Paul Strickland Scanner Centre, Mount Vernon Hospital, Rickmansworth Road, Northwood, HA6 2RN

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

Title: Mr/Mrs/Miss/Ms/Dr/Other:		Patient Type: NHS PRIVATE RESEARCH (RESEARCH TRIAL NAME & NUMBER)	
Surname:			
First Name:		OUTPATIENT INPATIENT	
DoB:	Sex: M F	Referring Hospital	
		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 If NO – a form 4 must be provided prior to patient attending	
Patient contact numbers:		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	
Email address:			
Communication: Preferred language: English Other If OTHER , specify preferred language: Please provide an English-speaking contact Name: Contact number::		Previous RT/Chemo date: Surgery/Biopsy: Date report required:	
GP name and address:		Medical history: 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	
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?	

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 (Do not copy and paste scan reports, these can be sent as an attachment if required):

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 :**