



PACIFIC RADIOLOGY
¹⁸F-PSMA Prostate PET/CT IMAGING REQUEST FORM

PLEASE COMPLETE BOTH SIDES, ENSURE FORM IS SIGNED BY THE REFERRING CONSULTANT
FAX COMPLETED REQUEST TO 04 978 5501. FOR ALL ENQUIRIES PHONE 04 978 5535.

Date results required by:	PATIENT IDENTIFICATION DETAILS OR STICKER NHI number: Surname: First name: Address: Phone numbers: Date of birth: Ethnicity: Maori NZ European /Other Pacific Peoples
Reason if <u>URGENT</u> request:	
PATIENT INFORMATION <input type="checkbox"/> Patient is an inpatient at: <input type="checkbox"/> Is patient claustrophobic? Yes / No Height: _____ cm Weight: _____ kg	

REFERRING CONSULTANT / SPECIALIST	
Name:	Referral Date:
Signature:	Phone contact:
Address:	Fax (if required):

ADDITIONAL REPORTS REQUIRED:		
Name:	Practice/Dept:	Fax:
Name:	Practice/Dept:	Fax:

CLINICAL INFORMATION	
Primary site of disease:	Histology / Pathology:
Date of Last Radiotherapy: ...dd.../...mm.../...yr...	Region:
Date of Last Treatment: ...dd.../...mm.../...yr...	Which cycle:
Date of Next Treatment: ...dd.../...mm.../...yr...	

FUNDING	<input type="checkbox"/> Private	<input type="checkbox"/> Medical Insurance	<input type="checkbox"/> DHB (please page two)
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RECENT CORRELATIVE IMAGING <input type="checkbox"/> CT Date: Provider/Where: <input type="checkbox"/> MRI Date: Provider/Where: <input type="checkbox"/> Other Date: Provider/Where:	RELEVANT FINDINGS
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FOR VIEWING OF PRIOR IMAGING ELECTRONIC TRANSFER TO PRL PACS or VIA CD ARE PREFERRED OPTIONS

Please select the appropriate clinical indication below and complete column appropriate to your selection.

For DHB Funded PET/CT scans:- Variance / exceptions basis indication

If the request is for a patient that does not meet the nationally approved clinical indications for PET scan please complete the section below

Cancer Type		Clinical Indication/Reason	
<p>Please forward to your DHB any supporting information (e.g. clinical multidisciplinary meeting reports or journal articles). <u>To be completed by the specialist authorising the PET/CT scan request for the DHB</u></p>			
Authorising specialist signature		DHB	
Authorising specialist name		Date Approved	