Northern Imaging VICTORIA
Northern Health

Northern Hospital Epping
PET-CT Department
P: (03) 8405 9600 I E: niv.reception@nh.org.au

PET/CT Scan Request

Full Name:

DOB: Sex:

Address:

Phone/Mobile Medicare No:

Appointment Date & Time (**NIV Use Only**):

Interpreter required? ☐ Yes ☐ No
Language requested:
Category: ☐ OP ☐ ED ☐ IP
Patient Location: Unit: Bed:

Requesting Consultant (All fields MUST be completed)

Full Name:

Provider no.:

Contact/Pager#: Unit/Specialty:

Signature: Date:

Copy Results to:

Clinical details

REQUESTED TRACER

☐ ^{18}FDG ☐ ^{18}F-PSMA
☐ DOTATATE ☐ .....

DIABETIC STATUS

☐ Nil ☐ Insulin-dependent
☐ Diet-controlled ☐ Non-insulin dependent

Diabetic Medication(s): .....

Primary site of disease: ..... Histopathology: .....

Patient Weight: ..... kg

Surgery type .....
Surgery date .....

Chemotherapy
Last Tx ..... Next Tx .....

Radiotherapy
Last Tx ..... Next Tx .....

Previous Imaging
CT: ...../...../..... at .....
MRI: ...../...../..... at .....
PET: ...../...../..... at .....

Clinical Question(s) & History

Date scan required by (optional):

Clinical Indications

DIAGNOSIS/STAGING

☐ **Solitary Pulmonary Nodule**
Evaluation for cases with unsuitable for or failed biopsy

☐ **Non-small Cell Lung Cancer**
Staging of new diagnosis

☐ **Head and Neck Cancer**
Staging of new diagnosis

☐ **Oesophageal/Gastro-oesophageal Junction Ca.**
Staging of cancer considered for active therapy

☐ **Lymphoma**
Staging of new diagnosis or previously untreated

☐ **Squamous Cell Carcinoma**
unknown primary site in cervical lymph nodes

☐ **Uterine Cervix Cancer**
Primary staging prior to RT or combined therapy

☐ **Sarcoma (except GIST)**
Initial staging for biopsy proven sarcoma

☐ **Breast Cancer**
Staging of locally advanced (Stage III) ca. for active therapy

☐ **Rare or uncommon cancers (once per dx)**
<12 cases per 100,000 persons/year; typically, FDG-avid.

REGSTAGING/MONITOR

☐ **Colorectal Cancer**
Suspected residual/MET(s)/recurrence for active therapy

☐ **Metastatic Melanoma**
Following initial therapy; suspected metastasis/recurrence

☐ **Head and Neck Cancer**
Suspected residual/recurrence after therapy

☐ **Lymphoma**
Assess response within 3 months of first-line therapy

☐ **Lymphoma**
Considered stem cell transplantation; post 2-line therapy

☐ **Lymphoma**
Restaging following confirmation of HL/NHL recurrence

☐ **Uterine Cervix Cancer**
Recurrence cancer for staging

☐ **Sarcoma (except GIST)**
Suspected residual/recurrence after definitive therapy

☐ **Breast Cancer**
Suspected Mets/recurrence; suitable for active therapy

☐ **Ovarian Cancer**
Following initial therapy, suitable for active therapy

Other PET/CT indications

Prostate Cancer

PSA level ..... *Date* ..... *Gleason Score* .....

☐ **Initial Staging (max. once per lifetime)**
Initial staging of intermediate to high-risk prostate cancer. Previously untreated and considered suitable for locoregional therapy with curative intent

☐ **Restaging (max. twice per lifetime)**
- PSA↑ 2ng/ml above nadir post-RT
- OR failure in PSA↓ to undetectable levels
- OR PSA after radical prostatectomy

GEP Neuroendocrine Tumours

Somatostatin Receptor (SSR) therapy – next injection due .....

☐ **GEP Neuroendocrine tumour**
Staging of suspected ca on the basis of biochemical evidence with negative or equivocal imaging; or surgically amenable GEP tumour identified and PET scan to exclude additional disease sites.

^{18}FDG Brain Indications

☐ **Alzheimer's Disease (max. 3 per lifetime)**
For diagnosis and quantitative assessment; equivocal findings determined by, or in consultation with, a clinical specialist; where a previous FDG Brain scan or NM SPECT-CT Brain scan has not been performed in the past 12 months.

☐ **Brain Tumour**
Evaluate suspected/residual/recurrence post-therapy (or with ongoing chemo); considered suitable for further therapy.

☐ **Refractory Epilepsy**
For refractory epilepsy being evaluated for surgery

☐ **Other Indication:** .....
Indications not listed on the Medicare Benefits Schedule may incur an out-of-pocket cost, with exception for Northern Health-referred patients. Please contact the PET Team on 8405 9600 for further information.

☐ **Request for Diagnostic CT (in addition to PET/CT)**

☐ CT Brain ☐ CT-Chest Abdomen Pelvis ☐ CT-IVP

Indication for Diagnostic CT .....

Examination/Body region requested for scanning .....

Diagnostic Imaging Use Only

Patient identification & procedure matching

☐ Full name ☐ D.O.B. ☐ Address

Correct examination: ☐ Y ☐ N

Correct side / site: ☐ Y ☐ N ☐ N/A

☐ Ward / Staff / Relative assisted with patient identification

The following processes have been confirmed prior to commencing:
☐ Justification ☐ Optimisation ☐ Approval ☐ Consent

Name & Position: **Signature:**

Patient Pregnancy & Breastfeeding Checklist

Pregnancy Status: ☐ Y ☐ N

Gestational age: .....

LMP: .....

Breastfeeding: ☐ Y ☐ N ☐ N/A

Patient signature:

Technologist notes

Your doctor has recommended you to use **Northern Imaging Victoria.**
Please discuss with your doctor before choosing a different imaging provider.