



PET/CT Imaging Request Form - Oncology

11/2011

IMPORTANT NOTES for referring Doctor/Specialist

Ensure both sides of this form are completed and that it is signed by the referring consultant, then email the completed form to petct@crg.co.nz or fax to 03 366 5755.

DHB Funded Scans

For a DHB funded scan, a copy of the completed form must also be emailed to petscans@cdhb.govt.nz or faxed to (03) 364 4165.

Patient information

(Circle and fill in appropriate areas)

- Height
Weight
Diabetic No / IDDM / NIDDM
Infectious Yes / No
Renal Failure Yes / No
Serum eGFR (last 3 months)
Previous IV contrast reaction Yes / No
Is the patient pregnant? Yes / No
Asthma Yes / No
Allergies? Yes / No
Inpatient / Outpatient
Interpreter needed?

Patient's details

Surname
First name(s) Attach label here
DOB NHI
Address
Phone (Home) (Work) (Mobile)
Date results required by

Will the patient require sedation? (e.g. for claustrophobia) Yes / No or a general anaesthetic? Yes / No

Consultant/Specialist details

Name NZMC No. Signature
Team (Phone) (Fax)
Address
Secretary's name Secretary's phone Date

Copy to

Name Address Fax
Name Address Fax

Funding - Please tick appropriate box

Private Medical Insurance DHB
Patient's DHB of service
Patient's DHB of domicile
AND select a DHB-approved indication on the 2nd page.

Clinical information on back of form. Please turn over and complete.

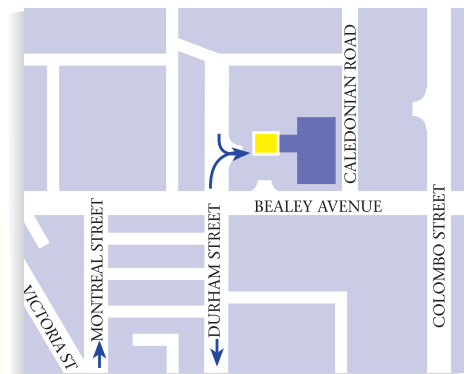


Southern Cross Radiology

129 Bealey Avenue, Christchurch
Hours: 8am - 5pm weekdays
Phones 0800 TOXRAY (0800 869 729) or (03) 366 5788
Fax (03) 366 5755 • Email petct@crg.co.nz • Website www.crg.co.nz

Important information for the patient

The procedure at Southern Cross Radiology will take at least 3 hours.
A personalised instruction sheet will be sent to the patient detailing the exact preparation that he/she will need to undertake prior to the scan.



Primary condition _____

Histology/Pathology _____

Please select one of the following

- New diagnosis / Initial staging
- Restaging / Surveillance
- Assess RX response

Previous malignancies _____

Clinical details _____

Known extent of disease (select all that apply)

- No evidence of disease
- Primary lesion site _____
- Local recurrence site _____
- Loco-regional involvement site _____
- Systemic disease site _____
- Equivocal site _____

Recent treatment details

- Surgery: Body location _____ Date _____
- Radiotherapy Chemotherapy Combined
- Date of last Radio/Chemo treatment _____
- Date of next Radio/Chemo treatment _____

What would your management plan be if PET were unavailable?

Intention of Plan: Curative OR Palliative

- Surgery Radiotherapy
- Chemoradiation alone Chemoradiation then surgery
- Chemotherapy alone Chemotherapy then surgery
- Biopsy Observation only
- Other _____

Recent relevant imaging

- CT Date _____
Provider / Where _____
- MRI Date _____
Provider / Where _____
- PET Date _____
Provider / Where _____
- Other Date _____
Provider / Where _____

Please arrange for transfer of relevant prior images to CRG or CDHB

Comments _____

DHB-Approved Indications - Must be completed for all DHB-funded cases.

A copy of this completed form must be sent to the petscans records office at CDHB. Contact details are on the front of this form.

Type	Indication	Select and tick One <input checked="" type="checkbox"/>
Colorectal	1. Preoperative evaluation for patients considered for resection of hepatic/lung metastases in colorectal carcinoma (CRC)	<input type="checkbox"/>
	2. Evaluation of residual structural abnormality on diagnostic imaging following definitive treatments for colorectal carcinoma (CRC)	<input type="checkbox"/>
Lung	3. Staging of proven non-small cell lung cancer (NSCLC) prior to curative surgery or radiotherapy	<input type="checkbox"/>
	4. Solitary pulmonary nodules not amenable to fine needle aspiration (FNA) or which have failed pathological characterisation	<input type="checkbox"/>
Lymphoma	5. Restaging of residual mass for Non-Hodgkin's Lymphoma following definitive treatment	<input type="checkbox"/>
	6. Staging of early stage low-grade Non-Hodgkin's Lymphoma	<input type="checkbox"/>
	7. Staging of Hodgkin's Disease	<input type="checkbox"/>
Head and Neck	8. Restaging of residual neck masses in head and neck cancers following radiotherapy/chemotherapy	<input type="checkbox"/>
	9. Staging for metastatic squamous carcinoma in cervical lymph nodes from unknown primary	<input type="checkbox"/>
Oesophagus	10. Staging of gastric/oesophageal cancer for curative treatment	<input type="checkbox"/>
Malignant Melanoma	11. Patients considered for definitive or adjuvant treatment of oligo-metastatic or regional melanoma	<input type="checkbox"/>
Cervical	12. Staging of locally advanced cervical cancer for curative radiation treatment	<input type="checkbox"/>
Ovarian	13. Restaging of recurrent ovarian carcinoma being considered for cytoreductive surgery	<input type="checkbox"/>

Other **The condition is outside the above criteria and will need to be approved by the PET Variance Committee.** Please forward your request and supporting information to the South Island PET Scan Variance Committee - Fax No: 03 366 5755, Email: petvariancecommittee@sissal.govt.nz