INHEALTH

PET/CT REQUEST FORM - PRIVATE PATIENTS

THIS FORM SHOULD BE COMPLETED IN CAPITALS.

Patient Information

NHS Number: ....

Hospital Number: ....

PACS Accession Number: ....

Name: ....

Address: ....

....

....

Post code: ....

Email: ....

Date of Birth: ....

Gender ☐ Male ☐ Female

Telephone: (Home) ....

(Work) ....

(Mobile) ....

GP Name: ....

Practice: ....

Practice Telephone: ....

PCT: ....

Is an interpreter required: ☐ Yes ☐ No

Is there any possibility of the Patient being pregnant?: ☐ **Yes** ☐ **No**

Is the patient breastfeeding? ☐ Yes ☐ No

Is the patient under 18 years old? ☐ Yes ☐ No

Is the patient diabetic? ☐ Yes ☐ No

Patient type: ☐ Inpatient ☐ Outpatient

Important Information (for inpatients only)

Ward: ....

Hospital: ....

Address: ....

....

Telephone: ....

Fax: ....

Request made by

Name: ....

Consultant: ☐ **Specialist Registrar:** ☐

Telephone contact: ....

Email contact: ....

Referring Trust Name: ....

Signature: ....**Date:** ....

All correspondance and report to be returned to NHS.net email: ....

SPECIAL INSTRUCTIONS

Pre-Booked Patients for:

Date: .... Site: ....

Booked by (name of MDT contact):

....

....

On: ....

Planned follow up Patient:

Please book scan for week commencing:

....

Urgent treatment Patient:

Result of scan required by:

....

On: ....

Research trials (where applicable)

Is this patient in a research trial? If so, please give the name of the trial and the contact of the Lead Researcher:

....

....

Does this referral meet locally agreed indications for scanning? ☐ **Yes** ☐ **No**

If you do not know check with your ARSAC holder.

INHEALTH

Self Pay: ☐ **Insured:** ☐

Insurance Company: ....

Policy Number: .... **Claim Authorisation Number:** ....

Patient Information

NHS Number: .... Clinical Indication Code (CRIS Code): ....

Name: .... ICD 10 Code: ....

Clinical Information

Diagnosis and details of primary tumour if known ....

....

....

....

....

Reason for Scan:

- ☐ Staging
- ☐ Identifying Primary
- ☐ Response to Therapy
- ☐ Recurrent Disease
- ☐ Grading
- ☐ Rising Tumour Markers
- ☐ Inflammation
- ☐ Infection
- ☐ Other – please state ....

Treatment details

Completion of Radiotherapy (date): ....

Chemotherapy: Type: .... Date of last cycle: ....

Date of next cycle: ....

Relevant previous images

Reports of relevant prior imaging must be sent with this referral form.

Relevant report attached: ☐ CT ☐ MRI ☐ U/S ☐ X-Ray ☐ PET/CT ☐ Other

Tick if reporter should review images: ☐ CT ☐ MRI ☐ U/S ☐ X-Ray ☐ PET/CT ☐ Other

Please do not send in prior images via the Image Exchange Portal (IEP) transfer. An image request will have to be made by InHealth in the IEP, before anything is sent.

TO BE FILLED IN BY ARSAC CERTIFICATE HOLDER ONLY

ARSAC authorisation

Name: .... **ARSAC Number:** ....

Signature: .... **Date:** ....

Scan required:

Head and Neck scan ☐ **Half Body scan (Eyes to Thighs)** ☐ **Half Body scan (Vertex to Thighs)** ☐

Other area (specify): ....

When complete please send to:

NHS PET/CT Diagnostic Imaging Service, IHMI Patient Referral Centre
Beechwood Hall | Kingsmead Road | High Wycombe | Buckinghamshire HP11 1JL
Tel: **0845 600 2953** | Fax: **0845 600 2954** | Email: **inl.petctsouth@nhs.net**

PLEASE SEND *BOTH* PAGES TO THE PATIENT REFERRAL CENTRE

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