

REQUEST FORM - ONCOLOGY PATIENTS

***Compulsory Information Fields. Failure to complete these fields will result in a delay of booking a patient appointment.**

PATIENT INFORMATION

*NHS Number:
 Hospital Number:
 PACS Accession Number:
 *Name:
 *Address:

 *Post code:
 *Date of Birth: dd/mm/yyyy
 *Gender Male Female
 *Telephone: (Home)
 (Work)
 (Mobile)
 *Email:
 *GP Name:
 *PCT:
 Is an interpreter required: Yes No
 *Patient type: Inpatient Outpatient
***Is there any possibility of the Patient being pregnant:** Yes No
 *Breastfeeding Yes No
 *Date of last menstrual period: dd/mm/yyyy
 *Is the patient under 18 years old?
 Yes No
 *Is the patient diabetic? Yes No
 Type I Type II

INPATIENT INFORMATION* (where applicable)

*Ward:
 *Hospital:
 *Address:

 *Telephone:
 *Fax:

REQUEST MADE BY

*Name:
 *Consultant: Specialist Registrar:
 *Telephone contact:
 *Email contact:
 *Referring Trust Name:
 Signature: Date: dd/mm/yyyy

PRE-BOOKED PATIENT FOR:

Date: dd/mm/yyyy 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:

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

All correspondence and report to be returned to

*NHS.net email: (this should be the generic Trust account)

PATIENT INFORMATION

*NHS Number:

*Name:

CLINICAL INFORMATION

*Clinical diagnosis:

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ICD 10 Code: Clinical Indication Code:

***Reason for Scan:**

Staging Grading

Recurrent Disease Response to Therapy

Identifying Primary Rising Tumour Markers

***Relevant Medical History**

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Notes/documentation attached Yes No

***Previous imaging**

Notes/documentation attached Yes No

Relevant imaging: CT MRI U/S X-Ray PET/CT Other

Have these images been sent to InHealth: Yes No

Current and proposed treatment

Recent surgery/biopsy (specify):

Radiotherapy (specify):

Chemotherapy: Type: Date of last cycle: dd/mm/yyyy

..... Date of next cycle: dd/mm/yyyy

TO BE FILLED IN BY ARSAC CERTIFICATE HOLDER ONLY

ARSAC authorisation:

Name: 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