PET CT PATIENT REFERRAL FORM

ميديكلينيك
MEDICLINIC

Please ensure that the Form is completed

PATIENT DETAILS

Patient Name _____ **Date of Birth** _____

Male ☐ **Female** ☐

Contact No. **E - mail**

REFERRING CLINICAN

Doctor _____ **Hospital** _____

Contact No. _____ **Email** _____

Signature _____ **Date** _____

Payment Option ☐ Insurance ☐ Self-Pay

Insurance Company _____ **Pre-Authorization No.** _____

Claim Status ☐ Applied ☐ Approved

SPECIFY STUDY AND INDICATION

DIAGNOSIS AND HISTORY

Histologically Proven ☐ Yes ☐ No

SCAN TYPE: FDG PET/CT

- Standard Oncology (18 FDG PET CT) ☐
- Total Body Oncology (Melanoma / Myeloma) ☐
- Cardiac ☐
- Brain ☐
- Infection Imaging ☐
- Other (Discuss in Advance) ☐

REASON FOR PET CT

- Diagnosis ☐
- Staging ☐
- Restaging after therapy ☐
- Monitoring Therapy Response ☐
- Suspected Recurrence ☐

Area _____

Diabetic ☐ Yes ☐ No

On Insulin ☐ Yes ☐ No

DATE LIST

Surgery _____ Area _____

Chemotherapy _____ Cycles _____

Radiotherapy _____ Sessions _____

Pregnant ☐ Yes ☐ No

Breast Feeding ☐ Yes ☐ No

HISTORY

Previous PET CT ☐ Yes ☐ No

Previous CT/MRI ☐ Yes ☐ No

Previous U/S ☐ Yes ☐ No

Previous X-Ray ☐ Yes ☐ No

Other

FOR DEPARTMENT USE

Protocol _____ ☐ Single Phase ☐ Dual Phase

Other Instructions

INSTRUCTIONS FOR PATIENTS

Low carbohydrate diet on the day before study. Avoid beverages (Tea, Coffee, Cola, etc.)

No heavy exercise one day before the scan.

Drink only water on the day of scan.

No food after midnight if study before 1pm. No food after 7am if study is after 1pm

Patients should bring all previous scan (PET CT/MRI/CT/US) reports & CD's and medical reports with them.

For Appointment Call - 04 4359660, Fax - 04 435 9918, E - mail MCH-Nuclearmedicine@mediclinic.ae