MonashImaging
Nuclear Medicine and PET
MonashHealth

PET Scan (PSMA)
Request Form

Nuclear Medicine & PET, Monash Imaging
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Identify

Patient Name: ______________________________
UR: ______________________________
DOB: ________________ M / F
Address: ______________________________
____
Phone: Mobile:
(Affix Patient's ID label here)

Is an interpreter required Y ☐
Language
____
Cubicle /Ward /Other Unit

MI Use only
Appt Date &Time

Referring Consultant Details
(Print) Name ______________________________ Provider number:________________
Pager No__________ Fax No_______________ Phone No________________ Mobile ________________
Address: ______________________________
Additional Copy of Report to:______________________________ Fax No________________

Situation

Clinical Details
Reason for PET Scan: ☐ 1. Diagnosis ☐ 2. Staging ☐ 3. Therapeutic Monitoring ☐ 4. Restaging
☐ 5. Other ______________________________

Clinical Staging: T ______ N ______ M ______	**Gleason Score / Tumour Grade:** ______________
Recent PSA Level: ____________________	**TRUS Biopsy: Date:** __________ **No Sites:** ________
Previous Surgery (Including Lymphadenectomy)	
Other Treatment (tick):	
☐ **Radiotherapy**	**Date/Site:**
☐ **Bracytherapy**	**Date/Site:**
☐ **Hormone Therapy**	**Date last given / ongoing:**
Additional Clinical History: (including previous history of other malignancies, co-morbidity, especially infection/inflammation):	

Pre PET (PSMA) management Plan (please circle):
Watchful wait Radical Prostatectomy Radiotherapy Hormone Therapy

Background

Please tick if relevant	
Are extra infection precautions in place?	☐
Claustrophobic?	☐
Creatinine / eGFR Date:	

Correlative Imaging (Please send relevant films and investigation results with patient)

Recent/ Previous Imaging	**Date:**	**Place/Provider**
☐ CT		
☐ MRI		
☐ Bone Scan		
☐ PET		

Assessment

Provisional Diagnosis:

Request

Examination Requested **68Ga-PSMA Scan** (low dose CT for attenuation correction and anatomical localisation)

Is Additional Imaging Required
(Tick appropriate box)
☐ **Separate diagnostic CT Scan (Region)** ____________________
☐ **Ultrasound (Region)** ____________________
☐ **Nuclear Medicine Scan (Type)** ____________________

PET results required by (please circle) : < 1 week / 1-2 weeks / 2-3weeks / 1 month or (Date):____________
I verify that this is the correct patient , correct side and site of imaging requested.

______________________________ ________________
Signature of Consultant/Specialist *Date*

173712 06/17

(insert patient label)

Monash Imaging Use Only

Intervention Team

Time Out (Interventional studies only, checklist completed by scout nurse, interventionist and imaging technologist

N.B. Performed immediately prior to commencement of intervention

1. Correct patient verified? ☐ Yes — Safe to proceed, step (2)
2. Procedure matches consent? ☐ Yes — Safe to proceed, step (3)
3. Correct side/site identified and marked with indelible pen? ☐ Yes N/A ☐ Safe to proceed, step (4)
4. L/R orientation confirmed on in-room monitor/image acquisition system ☐ Yes N/A ☐ Safe to proceed

MIT (initial) ....

Date: .... Time: ....

Interventionist / fellow / registrar: (PRINT name):.. Signed:..

Nurse (PRINT name):.. Signed:..

MIT / SONO / (PRINT name):.. Signed:..

Radiologist

Examination Details

Protocol:

Code: .... Dr Initials:.....................

Machine preference: ....

I.V. Contrast required Yes ☐ No ☐

Oral Contrast required Yes ☐ No ☐

Recall details / sequences as required:

CT MIT/ NMT

CT Preparation Checklist

Patient Name: ....

UR: ....

Height:..

Weight:...

Place IV contrast label here

3C's performed by	Yes ☐	No ☐
Previous CT's checked by	Yes ☐	No ☐
Recent eGFR	Yes ☐	No ☐
Remaining oral contrast given by	Yes ☐	No ☐
IV cannula checked by	Yes ☐	No ☐

.... (Please initial)

For Emergency or inpatients requiring IV contrast

Does the patient have hyperthyroidism?	Yes ☐	No ☐
Suspected or diagnosed thyroid cancer?	Yes ☐	No ☐
Known allergies including iodine?	Yes ☐	No ☐
Is the patient taking metformin?	Yes ☐	No ☐
Does the patient have sickle cell anaemia?	Yes ☐	No ☐
Does the patient have myasthenia gravis?	Yes ☐	No ☐
Does the patient take Beta Blockers?	Yes ☐	No ☐

Your doctor has recommended you use Monash Health.
You may choose another provider but please discuss this with your doctor first.