

Identify	Patient Name: _____ UR: _____ DOB: _____ M / F Address: _____ _____ Phone: _____ Mobile: _____ <i>(Affix Patient's ID label here)</i>		Is an interpreter required Y <input type="checkbox"/> 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: <input type="checkbox"/> 1. Diagnosis <input type="checkbox"/> 2. Staging <input type="checkbox"/> 3. Therapeutic Monitoring <input type="checkbox"/> 4. Restaging <input type="checkbox"/> 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): <input type="checkbox"/> Radiotherapy Date/Site: _____ <input type="checkbox"/> Brachytherapy Date/Site: _____ <input type="checkbox"/> 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		Correlative Imaging (Please send relevant films and investigation results with patient)		
	Are extra infection precautions in place?	<input type="checkbox"/>			
	Claustrophobic?	<input type="checkbox"/>	Recent/ Previous Imaging	Date:	Place/Provider
Creatinine / eGFR Date:		<input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Bone Scan <input type="checkbox"/> PET			
Assessment	Provisional Diagnosis: _____				
	Request	Examination Requested PSMA PET Scan (low dose CT for attenuation correction and anatomical localisation)			
Is Additional Imaging Required <input type="checkbox"/> Separate diagnostic CT Scan (Region) _____ (Tick appropriate box) <input type="checkbox"/> MRI (Region) _____ <input type="checkbox"/> 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.					
_____ <i>Signature of Consultant/Specialist</i>			_____ <i>Date</i>		

Patient Name/RIS Label:.....

Please select from the relevant list of studies below:

Medicare funded study:

- Staging:** Whole body prostate-specific membrane antigen (PSMA) positron emission tomography (PET)/computerised tomography (CT) study, performed for the initial staging of intermediate- to high-risk prostate adenocarcinoma, for a previously untreated patient who is otherwise considered suitable for locoregional therapy with curative intent.

Applicable only once per lifetime

- Restaging:** Whole body prostate-specific membrane antigen (PSMA) positron emission tomography (PET)/computerised tomography (CT) study, performed for the restaging of recurrent prostate adenocarcinoma, for a patient who has undergone prior locoregional therapy and who is otherwise considered suitable for further locoregional therapy to determine appropriate therapeutic pathways and timing of treatment initiation.

- o a prostate-specific antigen (PSA) increase of 2 ng/ml above the nadir after external beam radiotherapy (EBRT), OR
- o failure of PSA to fall to undetectable levels or rising serum PSA after radical prostatectomy.

Applicable only twice per lifetime

Non-Medicare funded studies:

- Other Indication: (Non-Medicare funded – these indications may attract a charge)

3 C's
Correct Patient Please tick 3 Patient Identifiers before commencing examination

 Full name DOB Address ID Bracelet Contact Ward / Relative to identify patient
Correct Procedure Yes No

(Patient verification & clinical history) Technologist:

Monash Imaging Services Offered

	General X-Ray	Fluoroscopy	CT Scanning	Ultrasound (Inc Doppler)	MRI	Angiography	Nuclear Medicine	PET	OPGG	Mammography	DEXA
Monash Medical Centre - Clayton 246 Clayton Rd Clayton Ph: 9594 2200 Fax: 9594 6687	●	●	●	●	●	●	●		●		●
Monash Children's Hospital - Clayton 246 Clayton Rd Clayton Ph: 9594 2200 Fax: 9594 6687	●	●		●	●						
Moorabbin Hospital Imaging 823-865 Centre Road Bentleigh East Ph: 9928 8828 Fax: 9928 8900	●	●	●	●	●		●	●		●	
Dandenong Hospital Monash Imaging 135 David Street Dandenong Ph: 9554 8175 Fax: 9554 8654 MRI Ph: 9554 8685 MRI Fax: 9554 8699	●	●	●	●	●	●	●		●		
Casey Hospital Diagnostic Imaging 62-70 Kangan Drive Berwick Ph: 8768 1279 Fax: 8768 1966	●	●	●	●			●		●	●	

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