



Date PET/CT required by: / /

Patient details

Name
DOB / /
Address
Telephone

Clinical Notes:

Tracer: ☐ 18F PSMA ☐ 18F FDG

Diagnostic Contrast CT: please tick box

☐ CT Brain ☐ CT C/A/P ☐ CT A/P ☐ CT IVP

PET indication: please tick box

Prostate	<input type="checkbox"/> Initial Staging: Intermediate to high risk prostate adenocarcinoma, untreated, considered for locoregional therapy. 1 scan per lifetime - 61563
	<input type="checkbox"/> Restaging: Whole body PSMA PET study performed for the restaging of recurrent prostate adenocarcinoma, has undergone locoregional therapy considered suitable for locoregional therapy. PSA increase of 2ng/ml above nadir post RT; or Failure of PSA to fall to undetectable levels; or Rising PSA after radical prostatectomy 2 scans per lifetime- 61564
Non Rebatable Indications:	<input type="checkbox"/> Prostate PSMA scan <input type="checkbox"/> Prostate FDG scan <input type="checkbox"/> PSMA scan for other indication

Indication for PET Scan:

<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Staging	<input type="checkbox"/> Therapeutic Monitoring	<input type="checkbox"/> Restaging	<input type="checkbox"/> Other
Clinical Staging: T N M			Gleason Score / Tumour Grade:	
Biopsy: Date: / / No Sites:			Recent PSA	
Histopathology	Infectious precautions Y <input type="checkbox"/> N <input type="checkbox"/>	eGFR	Date: / /	

Other Treatment (tick):

Surgery	Y <input type="checkbox"/> N <input type="checkbox"/>	Date: / / Site
Radiotherapy	Y <input type="checkbox"/> N <input type="checkbox"/>	Date: / / Site
Brachytherapy	Y <input type="checkbox"/> N <input type="checkbox"/>	Date: / / Site
Hormone Therapy	Y <input type="checkbox"/> N <input type="checkbox"/>	Date: / / Site

Additional Clinical History:

<input type="checkbox"/> Previous imaging:	Provider/Location	Date
<input type="checkbox"/> CT		/ /
<input type="checkbox"/> MRI		/ /
<input type="checkbox"/> Bone Scan		/ /
<input type="checkbox"/> PET		/ /

Referring doctor's details

Practitioner name
Provider number
Address
Phone Fax
Signature Date
Copy to

Internal use only

Pregnant Y ☐ N ☐
Patient identification verified ☐
Procedure and consent verified ☐
Tech name/position:

My appointment

Date

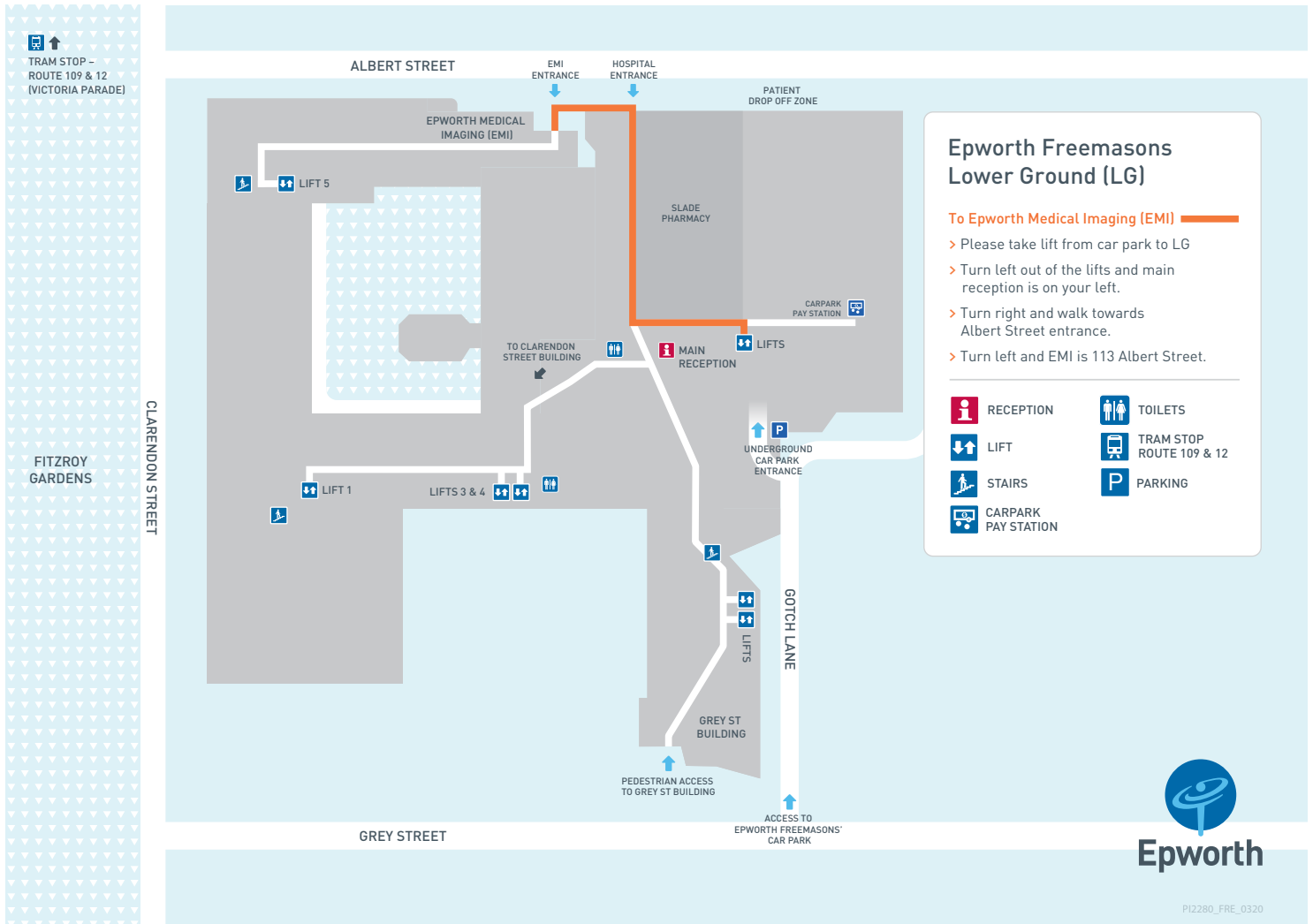
Location **Epworth Freemasons - 113 Albert Street East Melbourne**

Other

Time

Patient preparation

You will be provided with important patient preparation information for your PET/CT study.
For more information about your PET examination please visit epworthmedicalimaging.com.au



Your doctor has recommended you use Epworth Medical Imaging.
You may choose another provider but please discuss this with your doctor first.

Epworth Freemasons

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