Epworth Medical Imaging

Neurology PET CT Request/Referral

Patient details

Name .....
DOB / /
Address .....
.....
Medicare No. .....
Telephone .....

Chemotherapy: Last: ..... Next: .....
Radiotherapy: Last: ..... Next: .....
Infection Precaution: ☐ Yes ☐ No
Diabetic: ☐ Yes ☐ No
Metformin: ☐ Yes ☐ No
Date PET/CT required by: .....

Clinical Notes:

PET/CT Tracer: ☐ F18 FDG ☐ F18 FET ☐ 18F Florbetaben (Neuraceq)

Please tick PET indication and diagnostic CT requirements:			Diagnostic CT
Grouping	**Medicare eligible indication**	**PET**	**Brain**
Brain	FDG-Malignant brain tumour, after definite therapy (61538)		
	FDG- Refractory epilepsy , being evaluated for surgery (61559)		
	FDG - Diagnosis of Alzheimer's disease (61560) *(a) clinical evaluation of the patient by a specialist, or in consultation with a specialist, is equivocal;* *(b) includes a quantitative comparison of the results of the study with the results of an FDG PET study of a normal brain from a reference database.* *(c) 61560 has not been performed on the patient in the previous 12 months;* *(d 61402 not been performed on the patient in the previous 12 months for the diagnosis or management of Alzheimer's disease.*		
	Non-Rebatable indications	**PET**	**Brain**
Brain	FET – Used to diagnose, stage and re-stage brain tumours.		
	18F Florbetaben - Amyloid imaging for the detection of Alzheimer's Disease		

Results of prior Cognitive Decline Assessment:

MMSE score	30-25		20-24	13-20	Less than 12	
Pre –scan diagnosis	**Possible**	**Probable**			**Possible**	**Probable**
Normal	☐	☐	Fronto-temporal Dementia		☐	☐
Depression/anxiety	☐	☐	Dimentia with Lewey Bodies		☐	☐
Minimal cognitive impairment	☐	☐	Vascular dementia		☐	☐
Alzheimer's Disease AD (FTD)	☐	☐	Mixed AD and vascular dementia		☐	☐

Other:

Clinical Information:

Clinical Evaluation	Previous Imaging	Location/ Date	Medication
☐ EEG	☐ MRI	Site: ..... Date: ...../...../.....	
☐ Clinical evaluation	☐ CT	Site: ..... Date: ...../...../.....	
☐ Neuropsychologist	☐ NM SPECT	Site: ..... Date: ...../...../.....	
☐ Routine blood screen	☐ Ictal SPECT	Site: ..... Date: ...../...../.....	
☐ Invasive monitoring	☐ PETCT	Site: ..... Date: ...../...../.....	
☐ Surgery	☐ Other	Site: ..... Date: ...../...../.....	
☐ Histopathology		Site: ..... Date: ...../...../.....	

Referring doctor's details

Practitioner name .....
Provider number .....
Address .....
Phone ..... Fax .....
Signature ..... Date .....
Copy to .....

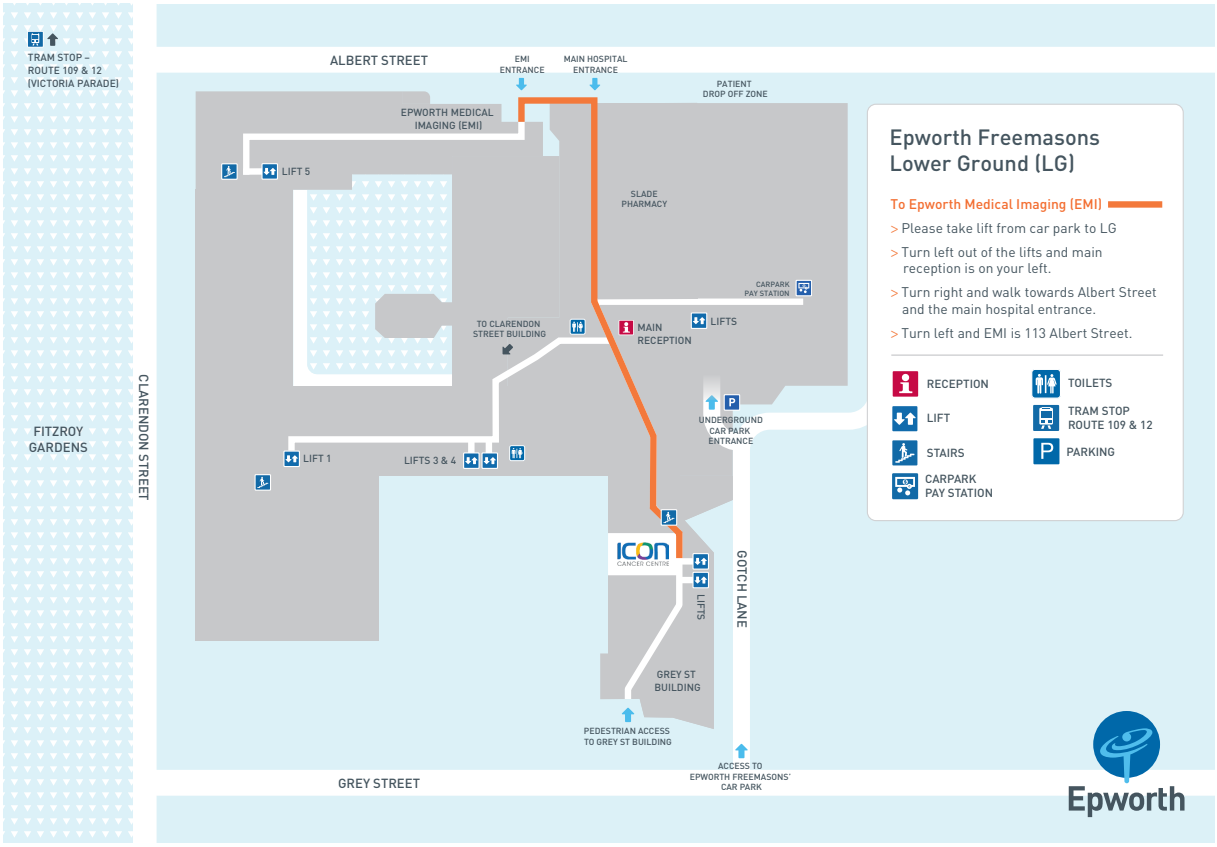
Internal use only

	Y	N
Pregnant	☐	☐
Patient identification verified	☐	
Procedure and consent verified	☐	

Tech name/position: .....
.....

Epworth Medical Imaging

Neurology PET/CT Request



Patient preparation

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

My appointment

Date .....

Location .....

Other .....

Time .....

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

Epworth Freemasons

113 Albert Street East Melbourne
Phone 03 9297 8200 | Fax 03 9297 8222
pet@emi.net.au

Thank you for referring your patient to Epworth Medical Imaging