SCANOMED
NUKLEÁRIS MEDICINA KÖZPONTOK

PET/CT REFERRAL FORM

1.) Patient Details:

First Name: _____ Surname: _____ Citizenship: _____ Sex: ☐male/ ☐female

Place/Date of birth: _____ / _____ Weigh: _____ kg; High: _____ cm

Type of Identity Card:_____ Number of Identity Card: _____

Postal Address: _____

Telephone: _____ Mobile: _____ E-mail:_____

2.) Referring Consultant Details:

Name: _____

Health centre: _____

Telephone: _____ Fax: _____ Mobile:_____ E-mail: _____

Date: .....

.....
Signature and stamp of referring consultant

3.) ScanoMed Medical, Diagnostic, Research and Training Ltd. is to fill this part!

Date of receiving the PET-CT Referral Form: **20☐☐ year ☐☐month ☐☐day**

Approving the FDG PET-CT examination request: **yes ❑ no ❑**

Main clinical field: **❑ oncology** **❑ neurology** **❑ cardiology** **❑ other**

Urgent: ❑ **To be scheduled from 20☐☐year ☐☐month ☐☐day**

Remark:_____

Date:_____ **Signature, stamp:**_____

4.) Information of health state

Asthma	yes☐ no ☐	Claustrophoby	yes☐ no ☐
Hyperthyreosis	yes☐ no ☐	Contrast media allergy	yes☐ no ☐
Diabetes	yes☐ no ☐	Infectious disease	yes☐ no ☐
Insulin therapy	yes☐ no ☐	Blood glucose level _____	mmol/l
Pregnancy	yes☐ no ☐	Serum creatinine level _____	mmol/l
		(in case of a diagnostic CT examination)	

Previous:

PET/CT examination	yes☐ no ☐	When? _____
CT examination	yes☐ no ☐	When? _____
MR examination	yes☐ no ☐	When? _____

ScanoMed Medical, Diagnostic, Research and Education Ltd.
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Account number: 12001008-00133317-00100003(HUF), 12001008-00133317-00200000(EUR)

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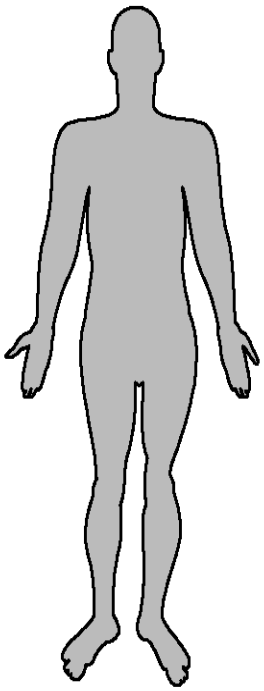
Reason for referral:

What question would you like to be answered:	 (Please indicate the site of primary disease or area under consideration)
Previous medical history, patient details, any valuable information:	

		Date of last treatment (year/month/day)	Type	Length (week)	Date of next treatment (year/month/day)
Surgery	yes ☐ no ☐	_____	_____		_____
Chemotherapy	yes ☐ no ☐	_____	_____	_____	_____
Radiotherapy	yes ☐ no ☐	_____	_____	_____	_____

Date: .....

..... Signature of patient or health care proxy

..... Signature and stamp of referring consultant

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