University Hospitals Coventry and Warwickshire NHS Trust

Nuclear Medicine Department, University Hospital,
Clifford Bridge Road, Coventry. CV2 2DX.

NHS
University Hospitals Coventry and Warwickshire
NHS Trust

PET/CT Request Form

Failure to complete all details may result in delay. Fields marked with an asterisk [*] must be completed.

Please send completed form to the Nuclear Medicine Department by secure e-mail.

Tel: 02476 968212 E-mail: uhc-tr.nucmedcoventry@nhs.net.

Patient details (please print) *

Surname:

Forename:

Date of birth:

NHS number:

Hospital number

Sex: ◯ Male / Female ◯

Full address:

Postcode:

Patient contact number:

GP name *:

Practice name *:

GP address:

GP postcode:

Clinical details (please print) *

Clinical information/history including site of primary disease or area under investigation:

Diagnostic question to be answered by test:

How will PET influence patient management?

When is scan required? *

Next available? Yes ☐ or specific date:

Does the patient have a history of venous access problems? ◯ Yes / No ◯

Referral information

MDT site: Date:

Name of radiologist present:

Referrer's details (person completing form, must be medical staff) *

Name (print):

Job title: GMC no.:

Signature: _____ Referral date:

Contact tel. number/bleep:

Referring consultant:
(if different from above)

Patient category *

NHS ◯ Private ◯ Self funded ◯

Research ◯ Please specify trial:

In-patient ◯ Hosp: Ward:

Out-patient ◯

Mobility

Walk ☐ Chair ☐ Bed ☐

Ambulance ☐

Special needs (please specify):

Previous relevant imaging *

Type: Hospital: Date:

Recent biopsies/relevant prior surgery *

(including those scheduled to be performed)

Date: Description: Result:

Chemotherapy * Type:

Last treatment date:

Next treatment date:

Number of cycles:

Radiotherapy * Site:

Last treatment date:

Next treatment date:

Immunotherapy * Type:

Last treatment date:

Next treatment date:

Medical status *

Infection risk: ◯ Yes / No ◯

Please specify:

Allergies:

Could the patient be pregnant ? ◯ Yes / No ◯

If yes: date of last menstrual period?

Is the patient breastfeeding? ◯ Yes / No ◯

Diabetic? ◯ Yes / No ◯

Diabetes treatment:

Diet ☐ Insulin ☐ Tablets ☐