PREMIER DIAGNOSTIC CENTER

REQUEST FOR CT and/or PETCT

• PATIENT INFORMATION (please print):

NAME:		DATE OF BIRTH	/ / MM DD YY
ADDRESS:		CARE CARD (PHN):	
CITY:		EMAIL:	
POSTAL / ZIP CODE:		SEX : ☐ MALE ☐ FEMALE	
TEL / CELL:		WEIGHT:	HEIGHT:

• EXAMINATION REQUESTED:

PET/CT WITH DIAGNOSTIC CONTRAST CT ☐ **DIAGNOSTIC CT SCAN ONLY ☐**

eGFR: _____ OR CREATININE: _____

PREVIOUS CONTRAST ALLERGIES? ☐ YES / ☐ NO / ☐ NO PREVIOUS CONTRAST STUDY

IF YES, PLEASE PROVIDE DETAILS OF REACTION: _____

PET/CT - NON CONTRAST ☐

• CLINICAL INDICATION FOR IMAGING REQUEST (MANDATORY):

DOES THIS PATIENT HAVE A KNOWN MALIGNANCY? NO ☐ / YES ☐ TYPE : _____

• ADDITIONAL PATIENT INFORMATION:

DIABETIC ☐ YES / ☐ NO

ON METFORMIN ☐ YES / ☐ NO

ALLERGIES ☐ YES / ☐ NO

SPECIFY _____

CLAUSTROPHOBIC ☐ YES / ☐ NO

NEEDS MOVEMENT AIDS ☐ YES / ☐ NO

BREAST FEEDING ☐ YES / ☐ NO

LMP / / MM DD YY

PREGNANT PATIENTS WILL NOT BE SCANNED

HEART CONDITION ☐ YES / ☐ NO

ASTHMA ☐ YES / ☐ NO

BLOOD DISORDER ☐ YES / ☐ NO

INFECTION CONCERN ☐ YES / ☐ NO

SPECIFY _____

• APPLICABLE DIAGNOSTIC IMAGING INFORMATION (PLS ATTACH):

PREVIOUS PET SCAN	☐ YES / ☐ NO	OTHER RECENT IMAGING	☐ YES / ☐ NO
DATE OF SCAN		TYPE (MRI, BONE, CT, ETC)	
HOSPITAL / CLINIC		HOSPITAL / CLINIC	

PATIENTS ARE ADVISED TO BRING RELEVANT PRIOR STUDIES AND FILMS

• RECENT TREATMENT:

CHEMOTHERAPY ☐ YES / ☐ NO	SURGERY / BIOPSY ☐ YES / ☐ NO	RADIOTHERAPY ☐ YES / ☐ NO
/ / MM DD YY	/ / MM DD YY	/ / MM DD YY

• REFERRING PHYSICIAN INFORMATION (MANDATORY):

NAME		TEL	
MSP #		FAX	
SIGNATURE		DATE	

SEND COMPLETED FORM TO: moa@petscan.ca | FAX: 604.678.9279

SUITE 300 - 3185 WILLINGDON GREEN, BURNABY, B.C. CANADA V5G 4P3

T:604.678.9274 | **F:**604.678.9279 | **TOLL FREE:**1.888.978.9115 | moa@petscan.ca