PET-CT Scan Referral Form

PET Centre, First Floor, Lambeth Wing, St Thomas' Hospital, Westminster Bridge Road, London, SE1 7EH
Tel No: 020 7188 1493 FAX No: 020 7620 0790

Please complete all sections of this form and click Submit at the bottom of the page.

PATIENT DETAILS

Surname:	First name:
Date of Birth:	◯ Male ◯ Female
Address:	
Post Code:	
Telephone No:	
Hospital Number:	
NHS Number:	
GP Details:	

REFERRING CONSULTANT

◯ Dr ◯ Mr ◯ Prof ◯ Ms	Surname:	First name:
Speciality:		
Hospital:		
If inpatient, contact details of ward:		
Phone No:	Fax No:	
Signature:	Bleep No:	
Date:	NHS.net email:	

FUNDING

◯ NHS ◯ Private Patient ◯ Self Pay ◯ Sponsored	
Private Insurance Details:	
Sponsorship Details:	

Reason for referral and clinical information (Please continue on a separate sheet if necessary):

MDM Date:	**OPA Date:**	**Two Week Wait Patient?** ◯ Yes ◯ No

PLEASE COMPLETE WHERE RELEVANT

	Type	Cycle Length	Date of Last Treatment	Date of Next Treatment
Surgery				
Chemotherapy				
Radiotherapy				

Is this patient diabetic?	Does this patient require sedation?	Could this patient present an infection risk?
◯ Tablet ◯ Insulin ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Referrer's responsibilities under IR(ME)R 2017

- Adequate details must be given to ensure that the identity of the individual can be verified prior to any radiation exposure
- The referral clearly identifies the referrer and that they are medically qualified
- If the individual is of child bearing age, pregnancy and breast feeding are considered to be relevant medical information
- Sufficient medical information has been given for the request to be justified according to IR(ME)R 2017 – this is a legal requirement
- The examination results are made available to relevant personnel directing the individual's care

For referral indications please see **http://sthpetcentre.org.uk/ForClinicians_Referrals/referrals.php**

Please click Submit once you have completed all fields.

Submit