Government of Western Australia
Department of Health

MYOCARDIAL VIABILITY REFERRAL FORM FOR PET SCAN

The Western Australian Positron Emission Tomography Service
Sir Charles Gairdner Hospital

YOU ARE FREE TO CHOOSE YOUR OWN IMAGING PROVIDER

Patient Information

Patient Identification

UMRN: _____
Surname: _____
First Name: _____
USE PATIENT LABEL WHEN AVAILABLE
DOB: _____ / _____ / _____ **Gender:** ☐ M ☐ F
Address: _____
Contact Details: **Home** _____
Mobile _____
Work _____

Date Results Required _____ / _____ / _____
☐ <3 days ☐ 1 week ☐ 2-3 weeks ☐ _____ months

Patient Information

- **Diabetic:** ☐ IDDM ☐ NIDDM ☐ No
- **Is patient claustrophobic?** ☐ Yes ☐ No
- **Height:** _____ **Weight:** _____
- **Is patient part of PET trial?** ☐ Yes ☐ No

If Yes, specify: _____

Referring Specialist

*Name: | *Phone:
Report to be sent to: | Mobile/Pager:
Fax:
Additional copies to:
*Signature: | Date: | *Provider No: (CONSULTANT ONLY)

Essential Information: illegible or incomplete forms will be returned to referrer

Clinical Information & Correlative Imaging

(Please ensure patient brings films/x-rays when attending the Centre for PET)

Cardiac Viability: An MPS study must be performed prior to PET scan referral.

History:
(Tick appropriate boxes)
☐ 1. Prior bypass surgery
☐ 2. Previous MI
☐ 3. Impaired left ventricular function

Standard Investigations Done:
(Tick appropriate boxes)
☐ 1. SPECT
☐ 2. Stress/dobutamine echo
☐ 3. Other, specify _____

Results of Standard Investigations:
☐ 1. Anterior
☐ 2. Lateral
☐ 3. Inferior
☐ 4. Septum
☐ 5. Apex
☐ 6. Inferior

Enter a viability code for each site
N = Non-viable
E = Equivocal
V = Viable

Appointment Date: _____ / _____ / _____ **Time:** _____ : _____

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