Government of **Western Australia**
Department of **Health**

NEUROLOGY 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

USE PATIENT LABEL WHEN AVAILABLE

UMRN:______________________________________

Surname: ___________________________________

First Name:__________________________________

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:

Report to be sent to:

*Provider No: Date:

*Phone:

Mobile/Pager:

Fax:

Additional copies to:

*Signature:

(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)

Reason for PET Scan: Please fill in A, B or C.

A. Intractable Epilepsy ☐ Yes ☐ No

Note: *Rebate available only for epilepsy when standard assessments are inconclusive.*

Type:
(circle)
1. Temporal lobe
2. Extra-temporal
3. Uncertain
4. Other

Lateralised:
(circle)
1. Left
2. Right
3. Not lateralised

Localisations ***OR*** ☐ **Not Localised** *(tick)*

☐ **Temporal**
☐ **Parietal**
☐ **Occipital**
☐ **Frontal**
☐ **Insula**

Enter a code for each site
A = Possible
B = Probable
C = Very Probable
D = Definite

Additional Clinical Notes:______________________________

SEE OVER

Appointment Date: ______ / ______ / ______ **Time:** ______ : ______

NEUROLOGY REFERRAL FORM FOR PET SCAN

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Level 1, G Block, Hospital Avenue, Nedlands, Western Australia 6009
Telephone + 618 6457 2322 Facsimile + 618 6457 3610 T.T.Y. Line + 618 6457 3900 Website: http://www.scgh.health.wa.gov.au, ABN: 13 993 250 709

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Scan	Done	Findings
CT/MRI	☐ Yes ☐ No	
EEG	☐ Yes ☐ No	
Video EEG	☐ Yes ☐ No	
Ictal SPECT	☐ Yes ☐ No	
Other	☐ Yes ☐ No	

B. Cognitive Decline ☐ Yes ☐ No

Pre-Scan Diagnosis: *(Tick one or more)*	Possible	Probable	Comments
Depression/anxiety	☐	☐	
Minimal Cognitive Impairment (MCI)	☐	☐	
Alzheimer's Disease (AD)	☐	☐	
Fronto-temporal Dementia (FTD)	☐	☐	
Diffuse Lewy Body (DEB)	☐	☐	
Vascular Dementia	☐	☐	
Other	☐	☐	

Additional Notes:____

Scan	Done	Findings
CT/MRI	☐ Yes ☐ No	
SPECT	☐ Yes ☐ No	
Neuropsychology Opinion	☐ Yes ☐ No	
Other	☐ Yes ☐ No	

C. Other ☐ Yes ☐ No

Clinical Details: ____

Scan	Done	Findings
CT/MRI	☐ Yes ☐ No	
SPECT	☐ Yes ☐ No	
Other	☐ Yes ☐ No	