timelymedical
alternatives

REQUEST FOR A **PET SCAN** REQUISITION

Timely Medical Alternatives Inc.
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MR | MRS. | MISS | MS

SURNAME: _____ **FIRST NAME:** _____ **MIDDLE INITIAL:** _____

ADDRESS: _____ **CITY:** _____ **PROVINCE:** _____

POSTAL CODE: _____ **PHONE** (work)**:** _____ **PHONE** (Home)**:** _____

DATE OF BIRTH: DD / MM / YY **AGE:** _____ **SEX:** _____

APPOINTMENT DATE: _____ **TIME:** _____

RELEVANT PREVIOUS FILMS

XRAY:
DATE: _____
LOCATION: _____

ULTRASOUND:
DATE: _____
LOCATION: _____

CT SCAN:
DATE: _____
LOCATION: _____

MRI SCAN:
DATE: _____
LOCATION: _____

PATIENT HISTORY:

DIABETIC?	YES	NO
WHEELCHAIR?	YES	NO
REQUIRES OXYGEN?	YES	NO
PT INCONTINENT?	YES	NO
PATIENT PREGNANT/ BREASTFEEDING?	YES	NO
RECENT CONTRAST	YES	NO
XRAY EXAMINATION?	YES	NO

PATIENT INFO:
HEIGHT: _____ cm
WEIGHT: _____ kg

F-18 – FLUORODEOXYGLUCOSE IMAGING PROCEDURE REQUESTED *(Please place a check beside procedure requested)*

ONCOLOGICAL DIAGNOSIS	YES	NO
BRAIN	YES	NO
MYOCARDIAL VIABILITY	YES	NO

RELEVANT CLINICAL INFORMATION/RECENT SURGERY

DATE OF LAST CHEMOTHERAPY OR RADIOTHERAPY: _____

INCOMPLETE REQUESTS WILL BE RETURNED

_____ M.D. _____ _____
SIGNATURE OF AUTHORIZING PHYSICIAN PLEASE PRINT NAME PRAC. NO.

PHONE NUMBER: _____ **ADDITIONAL COPY OF REPORT TO:** _____

FAX NUMBER: _____ **FAX NUMBER:** _____