BLACKROCK HEALTH
BLACKROCK CLINIC

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PET/CT Department

Patient Details
(Please Print)

Name: _____ Date of Birth:____/____/____

Address: _____

Mobile Phone: _____ Home Phone: _____

IN-PATIENT: Yes ☐ No ☐ **Previous Imaging attached:** ☐

Mobility: Mobile ☐ Needs assistance ☐ Order Number: _____

Priority of Referral

Routine ☐ Urgent ☐ Planned Scan (please specify date) ☐ _____

Oncological Indication

Diagnosis ☐ Response ☐ Recurrence Detection ☐ Staging ☐ Restaging ☐

Summary of Clinical History

Clinical information:

_____

_____

_____

_____

Questions to be answered:

_____

_____

Is the patient diabetic? Yes ☐ No ☐ Type 1 ☐ Type 2 ☐

Infection Control Issues: Yes ☐ No ☐ If yes, details _____

Date Last: Surgery: _____

Chemotherapy: _____

Radiation Therapy: _____

Imaging History

Previous PET/CT Yes ☐ No ☐ Reports Included ☐ Images Included ☐

Previous CT/ MRI Yes ☐ No ☐ Reports Included ☐ Images Included ☐

Referrer Details

Consultant Name: _____ Consultant Signature: _____
(BLOCK CAPITALS)

Consultant IMC Number:_____ Secretary's Contact Number: _____

Date of Request:_____ **Referring Hospital:**_____