Provincial Health Services Authority

PET/CT REQUISITION - Vancouver

Functional Imaging – Vancouver
PET Reception: (604)707-5951
PET Fax: (604)877-6245

Current Date: _____
Referring Physician: _____
Phone: _____
Fax: _____

For Department use only

Scan Date:_____Time:_____

Indication #:_____ 1A 1B 2 3
Details: _____
Routine H/N TB Brain ToH Arms: Up Down
Other: _____
Date:_____ PET Dr. Initial:_____

INCOMPLETE REFERRALS WILL BE RETURNED

Patient Information **Important:** **Height** _____ **Weight** _____ (kg / lb)
Name: _____ Preferred Name:_____
Surname First Middle
Date of Birth: D_____ M_____ Y_____ PHN: _____ Sex: Male / Female
Home Address: _____
Home Phone: ( ) _____ Work: ( ) _____ Mobile: ( ) _____
Temporary Address: _____ Temporary Phone:( ) _____
Family Physician: _____ Phone: ( ) _____
Patient mobility: ambulatory / wheelchair / stretcher

Diagnosis/Pertinent History
(include recent surgery, chemotherapy, radiotherapy):

If applicable, Clinical Trial Name: _____
Radiotracer Requested: _____
Contact Person: _____
Phone Number: _____

Specific Indication for PET/CT Request

Essential Information			Additional Information
Does patient require an interpreter?	Y ☐	N ☐	**Language:** _____
Does patient have any drug allergies?	Y ☐	N ☐	_____
Does patient have IV contrast allergies?	Y ☐	N ☐	_____
CT scan within 3 months?	Y ☐	N ☐	**Date:** _____
MRI scan within 3 months?	Y ☐	N ☐	**Date:** _____
Nuclear Med scan within 3 months?	Y ☐	N ☐	**Date:** _____
Previous PET or PET/CT scan?	Y ☐	N ☐	**Location/date:** _____

Doctor's Signature: _____ **MSP No**: _____

Additional Copies of Report to: _____

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Vancouver, BC V5Z 4E6
www.bccancer.bc.ca