สำหรับสติ๊กเกอร์

ชื่อ - สกุล.....

HN.....BD.....Age.....

Walk in Date.....Time.....

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Chiang Mai, Thailand 50200
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Email:PETCT.CMU@gmail.com
Web: http://www.med.cmu.ac.th/center/mec/main/

PET/CT Scan Request Form

Patient information

Patient Name: HN: Phone: Sex ☐ M ☐ F

DOB: DD/MM/YYYY Age: years Weight: kg Height: cm Creatinine: mg/dl

Ward: OPD:

Being pregnancy ☐ No ☐ Yes Iodine or other allergies ☐ No ☐ Yes, pls. indicate _____Claustrophobia ☐ No ☐Yes

DM ☐ No ☐ Yes, controlled by ☐ oral medication: pls. indicate_____ ☐ insulin: pls. indicate_____

Inflammation/infection in the past 3 months ☐ No ☐ Yes Disability ☐ No ☐ Yes

Diagnosis: pls. indicate _____ICD-10 code:

Staging: T N M Cell type:

Requested study

Oncologic PET

☐ Diagnosis	☐ Staging /Restaging
☐ Detection of recurrent disease	☐ Treatment monitoring/Treatment assessment
☐ Radiation treatment planning	

Cardiac PET

☐ Myocardial viability	☐ Perfusion/Blood flow/coronary flow reserve	☐ Cardiac inflammation

Neuro PET

☐ Dementia MMSE score:	☐ Parkinsonism
☐ Seizure	☐ Suspected recurrence of previously treated tumor
☐ Tumor viability/Radiation necrosis	☐ Radiation treatment planning

Indication for study and related history

:

Previous treatment

Surgery/intervention ☐ No ☐ Yes, date: DD/MM/YYYY Location: pls. indicate_____ *PET/CT should be done at next **4-6** weeks after surgery	Chemotherapy ☐ No ☐ Yes, date: DD/MM/YYYY *PET/CT should be done at next **6-8** weeks after last chemotherapy

Radiation ☐ No ☐ Yes, date: DD/MM/YYYY Location: pls. indicate_____
*PET/CT should be done at next **8-12** weeks after last date of radiation

Previous investigation (Please bring all images and results on examination date)

Ultrasonography ☐ No ☐ Yes, date: DD/MM/YYYY	CT ☐ No ☐ Yes, date: DD/MM/YYYY
MRI ☐ No ☐ Yes, date: DD/MM/YYYY	Other nuclear scan ☐ No ☐ Yes, date: DD/MM/YYYY
PET/CT ☐ No ☐ Yes, date: DD/MM/YYYY	Number of PET/CT in last 12 months:

Tumor marker ☐ No ☐ Yes, pls. indicate _____ date: DD/MM/YYYY

Referring Physician:		Mobile phone:
Email address:		
	Hospital phone number:	Requested Date: