Nuclear Medicine Center - PET/CT Unit *Equipped with Discovery 690 GE (General Electric), 64 Slice CT with TF*

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Request Form

Patient's Name: ..... Patient's Phone: .....

Gender: Female ☐ Male ☐ Age: .....Y/O Weight: .....kg Height: .....cm

Patient's History *(Please Describe)*

- **Diabetes:** ☐Yes ☐No

How is it controlled? ☐Oral Meds ☐Insulin ☐Other: .....

- **Recent Infection:** ☐Yes ☐No Date & Location: .....
- **Recent Fracture:** ☐Yes ☐No Date & Location: .....
- **Recent Surgery:** ☐Yes ☐No

Date & Location: .....

- **Recent Biopsy:** ☐Yes ☐No

Date & Location: .....

- **Radiation Therapy:** ☐Yes ☐No

Anatomic Location: ..... Date of Completion: .....

- **Chemotherapy:** ☐Yes ☐No

Name of Drug: ..... Date of Completion: .....

- **G-CSF:** ☐Yes ☐No Date of Last Dose: .....

(1) Please select the PET/CT requested: ☐Skull Base to Mid-Thigh (**Standard Exam**) ☐Limited Area: .....

☐Whole Body (Melanoma Exam) ☐Brain PET

(2) Type of Cancer

☐Hodgkin Lymphoma, *Subtype* .....

☐Non-Hodgkin Lymphoma, *Subtype* .....

☐Lung Cancer, *Subtype* .....

☐Solitary Pulmonary Nodule *(indeterminate nodule less than 3cm)*

☐Head & Neck Cancer ☐Thyroid Cancer ☐Esophageal Cancer ☐Breast Cancer

☐Cervical Cancer ☐Prostate Cancer ☐Colorectal Cancer ☐Melanoma

☐Other *(Please Specify)* .....

(3) Indication

☐Diagnosis ☐Primary Staging ☐Re-Staging ☐Metastasis ☐Response to Chemotherapy ☐Recurrence

☐Other *(Please Specify)* .....

Physician Email & Phone Number: ....

Physician Signature:

Attention:
If the question is evaluation of "treatment response", *baseline PET/CT* before treatment is recommended.