

Please ensure that this Requisition is also sent to the relevant medical scheme

Application for PET CT scan

Patient details	Referring physician
Surname <input style="width: 90%;" type="text"/>	Name and Surname <input style="width: 90%;" type="text"/>
Name <input style="width: 60%;" type="text"/> Title <input style="width: 20%;" type="text"/>	Practice number <input style="width: 90%;" type="text"/>
Date of Birth <input style="width: 20%;" type="text"/> Sex M/F <input style="width: 10%;" type="text"/>	PET CT practice: <input style="width: 90%;" type="text"/>
Medical aid <input style="width: 90%;" type="text"/>	Practice number <input style="width: 90%;" type="text"/>
Membership number <input style="width: 90%;" type="text"/>	

Diagnostic information

<p>Breast cancer <input type="checkbox"/></p> <p>Carcinoma of unknown primary <input type="checkbox"/></p> <p>Colorectal cancer <input type="checkbox"/></p> <p>Head and neck carcinoma <input type="checkbox"/></p> <p>Lymphoma Hodgkin's <input type="checkbox"/></p> <p>Lymphoma Non-Hodgkin's <input type="checkbox"/></p> <p>Melanoma <input type="checkbox"/></p> <p>Non-small cell lung carcinoma <input type="checkbox"/></p> <p>Oesophageal carcinoma <input type="checkbox"/></p> <p>Ovarian carcinoma <input type="checkbox"/></p> <p>Stomach carcinoma-GIST <input type="checkbox"/></p> <p>Testicular carcinoma <input type="checkbox"/></p> <p>Thyroid carcinoma <input type="checkbox"/></p> <p>Other <input type="checkbox"/></p>	<p>Clinical information</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div> <p>Clinical Diagnosis <input style="width: 90%;" type="text"/></p> <p>ICD-10 Primary <input style="width: 20%;" type="text"/> ICD-10 Secondary <input style="width: 20%;" type="text"/></p> <p>Tissue diagnosis <input style="width: 90%;" type="text"/></p> <p>Date <input style="width: 20%;" type="text"/> None <input type="checkbox"/></p> <p>Staging T <input type="checkbox"/> N <input type="checkbox"/> M <input type="checkbox"/> Grade <input style="width: 20%;" type="text"/></p> <p>If the member has metastases, please indicate site:</p> <p>Bone <input type="checkbox"/> Liver <input type="checkbox"/></p> <p>Brain <input type="checkbox"/> Lung <input type="checkbox"/></p> <p>Specify other: <input style="width: 90%;" type="text"/></p>
<p style="text-align: center;">Intervention and treatment</p> <p>Previous surgery date <input style="width: 20%;" type="text"/> None <input type="checkbox"/></p> <p><input style="width: 90%;" type="text"/></p> <p>Chemotherapy: last date(s) <input style="width: 20%;" type="text"/> None <input type="checkbox"/></p> <p><input style="width: 90%;" type="text"/></p> <p>Radiotherapy; last date(s) <input style="width: 20%;" type="text"/> None <input type="checkbox"/></p> <p><input style="width: 90%;" type="text"/></p>	

Previous work up (Please attach copy of report)

<p>X-ray Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>CT Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>MRI Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Ultrasound Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>PET CT scan Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Tumour markers Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Specify Other <input style="width: 90%;" type="text"/></p>
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PET Request	Intent
Full body PET CT scan <input type="checkbox"/>	Diagnosis <input type="checkbox"/>
Localised PET CT scan <input type="checkbox"/>	Initial staging <input type="checkbox"/>
Gamma PET scan <input type="checkbox"/>	Re-staging <input type="checkbox"/>
	Monitoring of treatment response <input type="checkbox"/>

ADDITIONAL PET-CT FORM**Please complete this section for****Discovery Health, MSO Administered Schemes, Pharos & Profmed members****1. History of previous PET scan (s)**

- i. Number of PET scans within last 12 months:
- ii. Please attach results of previous PET scans Yes No

2. Additional Clinical Information/ History to support this application**3. Consent to collection of data for outcomes measurement registry requirement**

I, (patient name in full), give the
 (name of medical scheme), or
its appointed agent, to collect all relevant medical or clinical information that is relevant to my
application for PET or PET CT scan for the evaluation of
 (name of condition) as requested either from myself or my
treating doctor (doctor's name in full).

The medical scheme will use the information for the purposes of measuring clinical outcomes and developing a registry that will allow the medical scheme to make informed funding decisions. The medical scheme will respect the confidential nature of the information at all times.

I understand that approval for funding for the scan is conditional upon me co-operating with all aspects of this pre-assessment.

Patient signature:**Date:****Physician's signature:****Date:**