

Application for PET CT scan

Patient details	Referring physician
Surname _____	Name and Surname _____
Name _____ Title _____	Practice number _____
Date of Birth YYYY / MM / DD Sex M / F	PET CT practice _____
Medical aid _____	Practice number _____
Membership number _____	

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>Tissue diagnosis</p> <p>Date YYYY / MM / DD None <input type="checkbox"/></p> <p>Clinical information</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
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Intervention and treatment	
Previous surgery date YYYY/MM/DD None <input type="checkbox"/>	Diagnosis _____
_____	ICD-10 Primary _____
Chemotherapy: last date(s) YYYY/MM/DD None <input type="checkbox"/>	ICD-10 Secondary _____
_____	Staging
Radiotherapy; last date(s) YYYY/MM/DD None <input type="checkbox"/>	T _____ N _____ M _____ Grade _____
_____	If the member has metastases, please indicate site:
	Bone <input type="checkbox"/> Liver <input type="checkbox"/>
	Brain <input type="checkbox"/> Lung <input type="checkbox"/>
	Specify other: _____

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 _____</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"/>

Physician's signature: _____

Date: _____

Please complete this section for Discovery Health members

1. History of previous PET scan (s)

i. Number of PET scans within last 12 months _____

i. Please attach results of previous PET scans

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 Discovery Health 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:** _____