



Application for PET CT scan

| Patient details | Referring physician |
|---|---------------------------------------|
| Surname <input type="text"/> | Name and Surname <input type="text"/> |
| Name <input type="text"/> Title <input type="text"/> | Practice number <input type="text"/> |
| Date of Birth <input type="text"/> Sex M/F <input type="text"/> | PET CT practice: <input type="text"/> |
| Medical aid <input type="text"/> | Practice number <input type="text"/> |
| Membership number <input type="text"/> | |

Diagnostic information

| | |
|--|---|
| Breast cancer <input type="checkbox"/> Carcinoma of unknown primary <input type="checkbox"/> Colorectal cancer <input type="checkbox"/> Head and neck carcinoma <input type="checkbox"/> Lymphoma Hodgkin's <input type="checkbox"/> Lymphoma Non-Hodgkin's <input type="checkbox"/> Melanoma <input type="checkbox"/> Non-small cell lung carcinoma <input type="checkbox"/> Oesophageal carcinoma <input type="checkbox"/> Ovarian carcinoma <input type="checkbox"/> Stomach carcinoma-GIST <input type="checkbox"/> Testicular carcinoma <input type="checkbox"/> Thyroid carcinoma <input type="checkbox"/> Other <input type="checkbox"/> | Clinical information <div style="border: 1px solid black; height: 150px; width: 100%;"></div> |
|--|---|

Intervention and treatment

| | |
|--|--|
| Previous surgery date <input type="text"/> None <input type="checkbox"/> <input type="text"/> Chemotherapy: last date(s) <input type="text"/> None <input type="checkbox"/> <input type="text"/> Radiotherapy; last date(s) <input type="text"/> None <input type="checkbox"/> <input type="text"/> | Clinical Diagnosis <input type="text"/> ICD-10 Primary <input type="text"/> ICD-10 Secondary <input type="text"/> Tissue diagnosis <input type="text"/> Date <input type="text"/> None <input type="checkbox"/> Staging T <input type="checkbox"/> N <input type="checkbox"/> M <input type="checkbox"/> Grade <input type="text"/> 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: <input type="text"/> |
|--|--|

Previous work up (Please attach copy of report)

| | |
|--|---|
| X-ray Yes <input type="checkbox"/> No <input type="checkbox"/> CT Yes <input type="checkbox"/> No <input type="checkbox"/> MRI Yes <input type="checkbox"/> No <input type="checkbox"/> Ultrasound Yes <input type="checkbox"/> No <input type="checkbox"/> | PET CT scan Yes <input type="checkbox"/> No <input type="checkbox"/> Tumour markers Yes <input type="checkbox"/> No <input type="checkbox"/> Specify Other <input type="text"/> |
|--|---|

PET Request

Intent

| | |
|--|--|
| Full body PET CT scan <input type="checkbox"/> Localised PET CT scan <input type="checkbox"/> | Diagnosis <input type="checkbox"/> Initial staging <input type="checkbox"/> Re-staging <input type="checkbox"/> Monitoring of treatment response <input type="checkbox"/> |
|--|--|

Radiologists linked to this referral

- | | |
|---|---|
| <input type="checkbox"/> Drs Coetzer & Bartlett Inc. | <input type="checkbox"/> Dr Tuft & Partners Inc. |
| <input type="checkbox"/> Dr Cronje & Partners Inc. | <input type="checkbox"/> Dr Symington & Partners. |
| <input type="checkbox"/> Dr Morton & Partners | <input type="checkbox"/> Dr WE Scribante & Partners Inc |
| <input type="checkbox"/> Drs Movsowitz Conway & Ass. Inc. | <input type="checkbox"/> Dr van Wageningen & Partners Inc |
| <input type="checkbox"/> Drs Schnetler, Corbett & Partners Inc. | <input type="checkbox"/> Other |

Physician's signature:

Date:

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:**