

Site Address:

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Practice No.: 0229083

Administration/Accounts:

P.O. Box 15094
 Panorama
 7506

Application for PET CT scan

Patient details	Referring physician
Surname _____ Name _____ Title _____ Date of Birth ____/____/____ Sex M / F Identity number _____ Medical aid _____ Membership number _____	Name and Surname _____ Practice number _____ Consulting Room Location _____ <i>(Indicate the location of the rooms where the consultation with the patient was held)</i>
Please tick study requested	PET CT practice Cape PET-CT Centre Practice number 0229083
F-18 FDG Wholebody <input type="checkbox"/> Ga-68 DOTATATE <input type="checkbox"/> Brain <input type="checkbox"/> F-DOPA Cardiac <input type="checkbox"/> Wholebody <input type="checkbox"/> Ga-68 PSMA <input type="checkbox"/> Brain <input type="checkbox"/>	Diagnostic information Clinical information <div style="border: 1px solid black; height: 300px; width: 100%;"></div>
Intent Diagnosis <input type="checkbox"/> Initial staging <input type="checkbox"/> Re-staging <input type="checkbox"/> Suspected recurrence <input type="checkbox"/> Treatment response (Interim) <input type="checkbox"/> Treatment response (End of treatment) <input type="checkbox"/>	
Intervention and treatment Previous surgery date ____/____/____ None <input type="checkbox"/> _____ Chemotherapy: last date(s) ____/____/____ None <input type="checkbox"/> _____ Radiotherapy: last date(s) ____/____/____ None <input type="checkbox"/> _____	
Previous work up (Please attach copy of reports) 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 _____	Clinical diagnosis _____ ICD-10 Primary _____ ICD-10 Secondary _____ Morphology code _____ Tissue diagnosis Date ____/____/____ None <input type="checkbox"/> Histology (Please attach report) _____ Staging T _____ N _____ M _____ Grade _____

Radiology practice linked to this referral

- | | |
|---|--|
| <input type="checkbox"/> Drs Coetzer & Bartlett Inc. | <input type="checkbox"/> Dr WE Scribante & Partners Inc. |
| <input type="checkbox"/> Worcester Radiology | <input type="checkbox"/> Bergman Ross & Partners |
| <input type="checkbox"/> Dr Morton & Partners | <input type="checkbox"/> Winelands Radiology |
| <input type="checkbox"/> Drs Movsowitz Conway & Ass. Inc. | <input type="checkbox"/> Cape Radiology |
| <input type="checkbox"/> SCP Radiology | <input type="checkbox"/> Other |
| <input type="checkbox"/> Kingsbury Radiology JV | |

Physician Signature: _____

Date: _____

ADDITIONAL DISCOVERY PET-CT FORM

Please complete this section for Discovery Health members

1. History of previous PET scan (s)

i. Number of PET scans within last 12 months _____

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, permission 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: _____