Site Address:
Room 20 Mediclinic Panorama Annex
Hennie Winterbach Street Panorama
Tel: (021) 930 4753
Email: info@petct.co.za or bookings@petct.co.za

Cape PET-CT Centre

Practice No.: 0229083

Administration/Accounts:
P.O. Box 15094
Panorama
7506

Application for PET CT scan

Patient details

Surname _____

Name _____ Title _____

Date of Birth _____/____/____ Sex M / F

Identity number _____

Medical aid _____

Membership number _____

Referring physician

Name and Surname _____

Practice number _____

Consulting Room Location _____
(Indicate the location of the rooms where the consultation with the patient was held)

PET CT practice ***Cape PET-CT Centre***

Practice number **0229083**

Please tick study requested

F-18 FDG

Wholebody ☐
Brain ☐
Cardiac ☐
F-18 / Ga-68 PSMA ☐

Ga-68 DOTATATE ☐

F-DOPA

Wholebody ☐
Brain ☐

Intent

Diagnosis ☐
Initial staging ☐
Re-staging ☐
Suspected recurrence ☐
Treatment response (Interim) ☐
Treatment response (End of treatment) ☐

Intervention and treatment

Previous surgery date _____/____/____ None ☐

_____

Chemotherapy: last date(s) _____/____/____ None ☐

_____

Radiotherapy: last date(s) _____/____/____ None ☐

_____

Previous work up (Please attach copy of reports)

X-ray	Yes ☐	No ☐
CT	Yes ☐	No ☐
MRI	Yes ☐	No ☐
Ultrasound	Yes ☐	No ☐
PET CT scan	Yes ☐	No ☐
Tumour markers	Yes ☐	No ☐

Specify Other _____

Diagnostic information

Clinical information

Clinical diagnosis _____

ICD-10 Primary _____ ICD-10 Secondary _____

Morphology code _____

Tissue diagnosis Date _____/_____/_____ None ☐

Histology (Please attach report) _____

Staging T _____ N _____ M _____ **Grade** _____

Radiology practice linked to this referral

☐ Mossel Bay Radiology
☐ Dr Morton & Partners
☐ SCP Radiology
☐ Kingsbury Radiology JV
☐ Garden Route Radiology
☐ Bergman Ross & Partners
☐ Winelands Radiology
☐ Cape Radiology
☐ Other

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:** _____