Alberta Health Services

PET/CT Imaging Request

- Fax to Diagnostic Imaging; fax numbers listed at http://www.albertahealthservices.ca/diagnosticimaging
- *Urgent/Emergent requests must be discussed by direct consultation with the radiologist*

Preferred Facility
No Preference

Patient label here or information below is required	
Last Name	First Name
Birthdate *(yyyy-Mon-dd)*	Gender
Address (street, city, province, postal code)	
PHN	Daytime Phone
Inpatient location	

Referring Physician (***PRINT*** *first and last name)*	Physician Phone *(required)*	Physician Fax *(required)*	Contact Number for Critical Test Results *(required)*

Signature	Date *(yyyy-Mon-dd)*	Copy to Physician *(first and last)*	Copy to Fax

Specific anatomical area to be examined/name of exam

Diagnostic CT
☐ Yes
☐ No

Relevant clinical history/presumptive diagnosis

Clinical question to be answered

Relevant Previous Imaging Studies

Location	Type	Date *(yyyy-Mon-dd)*	Attached copy
			☐ No ☐ Yes

Previous Treatment	**No**	**Yes**	**If Yes:**	
Treatment			Start Date *(yyyy-Mon-dd)*	Completion Date *(yyyy-Mon-dd)*
Radiotherapy	☐	☐		
Chemotherapy	☐	☐		
Marrow Stimulant Therapy	☐	☐		
Other, *specify:*	☐	☐		
Surgery/Biopsy	☐	☐	*Specify procedure:*	*Date:*

Current Patient Condition

Condition	**No**	**Yes**	**If Yes:**
Diabetes	☐	☐	
Allergies	☐	☐	Specify:
Pregnant ☐ n/a	☐	☐	Date of LMP:
Claustrophobia	☐	☐	*Driver needed if patient given Ativan*
Renal insufficiency	☐	☐	
Mechanical lift/ transfer required	☐	☐	Specify:
Research Study	☐	☐	Study name: Study Number:

Nuclear Medicine Physician Only Date format: *yyyy-Mon-dd* - Time format: *hh:mm*

Date Received	Time Received	Appointment Date	Appointment Time
Priority ☐ OP1 ☐ OP2 ☐ OP3 ☐ OP4, *Specify date*:		Protocol	Radiologist