NUCLEAR MEDICINE
IMAGING REQUEST FORM

Health
South Western Sydney
Local Health District

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PATIENT DETAILS:

MRN: ____________________

Name: ____ D.O.B: ____/____/____ SEX: M / F

Address: ____

Phone (H): ________________________ (W) ________________________ (M) ________________________

NIDDM/IDDM: _________ Outpatient (tick) ❑ or Inpatient ❑: Hospital: ______________ Ward: _____

Weight (KG): ____________ Interpreter Required: No ❑ or Yes ❑ (please specify) ______________________

TYPE OF STUDY REQUESTED: Please tick test required

- ❑ Biliary Scan (HIDA)
- ❑ Bone Scan
- ❑ Bone Mineral Densitometry (DEXA)
- ❑ C14 Urea Breath Test
- ❑ Cerebral Perfusion SPECT
- ❑ Colonic Transit
- ❑ Gallium Scan
- ❑ Gastric Emptying
- ❑ Gated Heart Pool Scan
- ❑ Lung VQ Scan
- ❑ Myocardial Perfusion Sestamibi: Exercise
- ❑ Myocardial Perfusion Sestamibi: Persantin
- ❑ Other Studies not listed (Please specify below)
- ❑ Myocardial Viability
- ❑ Parathyroid Scan
- ❑ Red Blood Cell Liver Scan
- ❑ Renal MAG3 ❑with Lasix
- ❑ Renal DMSA
- ❑ Renal DTPA ❑with Lasix
- ❑ Renal DTPA ❑with GFR
- ❑ Renal GFR only with 99mTc-DTPA
- ❑ Renal GFR only with 51Cr-EDTA
- ❑ Sentinel Node Scan
- ❑ Thyroid Scan
- ❑ Therapy consultation: radioiodine
- ❑ White Blood Cell Scan

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REASON FOR EXAMINATION and SUMMARY OF CLINICAL NOTES:

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REFERRING DOCTOR: (Please provide full details and signature)

Name: ______________________________________ **Provider No:** ____________________

Phone: ____________________ Fax: ____________________ Signature: ____________________

Address: ____ Date: ______________

Email: ____

Please note: As the patient you have the option to choose your diagnostic imaging provider
For more information, please visit our website: http://www.swslhd.nsw.gov.au/liverpool/pet