Alberta Health Services

PET/CT Imaging Request

- All fields must be completed for form to be processed
- 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*

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown	

Preferred Facility		Inpatient Location
Patient Phone Number *(Cell # preferred)*		Patient Address
City	Postal Code	WCB Claim Number
Ordering Provider Name	Provider ID	Department ID
Provider Fax	Provider Phone	Contact Number for Critical Test Results
Provider Address/Location	City	Postal Code

Locum ☐ No ☐ Yes ► Primary Provider Name and Provider ID _____

Signature	Date *(dd-Mon-yyyy)*	Copy to Provider *(last,first and middle)*	Copy to Fax

Requested Procedure — Diagnostic CT ☐ No ☐ Yes

Reason for Exam

Clinical question to be answered

Relevant Previous Imaging Studies

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

Previous Treatment	**No**	**Yes**	**If Yes:**	
Treatment			**Start Date** *(dd-Mon-yyyy)*	**Completion Date** *(dd-Mon-yyyy)*
Radiotherapy	☐	☐		
Chemotherapy	☐	☐		
Marrow Stimulant Therapy	☐	☐		
Surgery/Biopsy	☐	☐	*specify procedure* _____	
Other, *specify* _____	☐	☐		
Condition	**No**	**Yes**	**If Yes:**	
Pregnant ☐n/a	☐	☐	Date of LMP: _____	Date of BHCG: _____
Pediatric/Special Needs	☐	☐	Requires sedation ☐ No ☐ Oral ☐ IV ☐ Anesthesia	
Isolation Precautions	☐	☐	Specify:	
Diabetic	☐	☐		
Allergies *(include any reaction to contrast media)*	☐	☐	Specify:	
Claustrophobia	☐	☐	Driver needed if patient given Ativan	
Mechanical lift/transfer required	☐	☐	Specify:	
Research Study	☐	☐	Study Name: _____	Study Number: _____

Renal Insufficiency ☐ No ☐ Yes
On Dialysis ☐ No ☐ Yes ► run days:_____

If no current GFR results available, please indicate date last ordered *(dd-Mon-yyyy)* _____

Serum Creatinine *(within 90 days)* _____ GFR *(within 90 days)* _____ Date *(dd-Mon-yyyy)* _____

Nuclear Medicine Physician Use Only

Date Received *(dd-Mon-yyyy)*	Time Received *(hh:mm)*	Date of Appointment *(dd-Mon-yyyy)*	Time of Appointment *(hh:mm)*

Priority ☐ OP1 ☐ OP2 ☐ OP3 ☐ OP4, Specify date: _____ | Clerk Initial | Radiologist Name