JABATAN PERUBATAN NUKLEAR
TINGKAT 1
BANGUNAN RADIOTERAPI & ONKOLOGI
HOSPITAL KUALA LUMPUR

HKL/NUK/AK-03-07(a)

☎ Tel: 03-2615 5836
✉ nuklearpethkl@moh.gov.my

REQUEST FORM FOR PET-CT IMAGING

Please fill up the relevant information with a copy of pathology and relevant imaging results and email to nuklearpethkl@moh.gov.my. Please tick (√) in the box required.

Appointment will be given once completed form is submitted. Please call 03-2615 5836 for confirmation.

Patient's Name:		Gender :	Ethnic group :
I/C No :	Date of Birth :	Age :	Contact No :
Address :		Payment Category: ☐ Full Pay ☐ Free* ☐ Others * Please provide GL / school letter or pensioner / JK /OKU / JAKOA card	

Patient category: ☐ In-patient (Ward/Hospital):_____ ☐ Outpatient

Type of Appointment Required:

☐ Urgent ☐ Normal ☐ Early/Preferred Date:

Relevant History:

Diabetic : ☐ No ☐ Yes Medications: _____
Claustrophobic : ☐ No ☐ Yes
Pregnant : ☐ No ☐ Yes L.M.P : _____

Patient's condition : ☐ Walking ☐ Wheelchair ☐ Stretcher ☐ O_2 support

Clinical Diagnosis & Primary Site:
(please specify stage of disease)

Indication for PET-CT study :

Oncology

- ☐ Evaluation of unknown primary
- ☐ Evaluation of solitary pulmonary nodule
- ☐ Staging of newly diagnosed malignancy
- ☐ Restaging when clinical/structural/biochemical suspicion of recurrence
- ☐ Interim
- ☐ Evaluation of post-treatment response
- ☐ Identification of biopsy site for cancer
- ☐ Surveillance
- ☐ Evaluation of non-iodine avid disease

Infection / Inflammation

- ☐ Evaluation of pyrexia of unknown origin
- ☐ Evaluation of vasculitis i.e. Takayasu's & giant cell arteritis

Neurology

- ☐ Evaluation of dementia
- ☐ Evaluation of inter-ictal seizure focus
- ☐ Evaluation of movement disorder
- ☐ Encephalitis

Others: _____

Concise clinical summary and physical examination:

Relevant Imaging (To attach report): (For CT, MRI & other imaging please state area of examination)	
☐ CT scan	Date & Report:
☐ MRI	Date & Report:
☐ PET-CT	Date & Report:
☐ Other imaging	Date & Report:
Relevant Biochemical Markers:	
Treatment:	
☐ Surgery Date:	Type of surgery: Findings/Histopathology:
☐ Radiotherapy Date:	Site / Dose:
☐ Chemotherapy Date:	Cycles & Regimes:
☐ Others (specify) Date:	

Referring consultant / specialist:

Name: _____

Department & Hospital: _____

_____

E-mail address: _____

Tel. No.: _____

Fax No.: _____

Signature and Official Stamp:

_____

Date:

* Referring doctor may be called to clarify request

APPOINTMENT DATE :

(To be filled by PET-CT staff)

Note To Clinician: FDG PET-CT is less sensitive for the following tumours: Prostate adenocarcinoma, mucinous adenocarcinoma, renal cell carcinoma, broncho-alveolar carcinoma, well-differentiated neuroendocrine tumour, well-differentiated thyroid carcinoma, and low grade lymphoma/ sarcoma.

Check List:

- ☐ Completed form with specialist signature & official stamp
- ☐ Relevant blood investigation results i.e. tumour markers, serology, culture & sensitivity etc.
- ☐ Imaging report (CT, MRI, USG, NM imaging & others)
- ☐ Contactable phone number (patient & referring doctor)
- ☐ Imaging film or CD for patient to bring along during appointment
- ☐ Interdepartmental transfer form (in-patient cases)