Print Form

SAOC PET OFFICE FAX (012) 667-4795
SAOC PET OFFICE TEL (012) 667-2067
SAOC PET E-MAIL pet@saoc.org.za

Please ensure that this Requisition is also sent to the relevant medical scheme

Application for PET CT scan

Patient details

Surname

Name | Title

Date of Birth | Sex M/F

Medical aid

Membership number

Referring physician

Name and Surname

Practice number

PET CT practice:

Practice number

Diagnostic information

- Breast cancer ☐
- Carcinoma of unknown primary ☐
- Colorectal cancer ☐
- Head and neck carcinoma ☐
- Lymphoma Hodgkin's ☐
- Lymphoma Non-Hodgkin's ☐
- Melanoma ☐
- Non-small cell lung carcinoma ☐
- Oesophageal carcinoma ☐
- Ovarian carcinoma ☐
- Stomach carcinoma-GIST ☐
- Testicular carcinoma ☐
- Thyroid carcinoma ☐
- Other ☐

Clinical information

Intervention and treatment

Previous surgery date | None ☐

Chemotherapy: last date(s) | None ☐

Radiotherapy; last date(s) | None ☐

Clinical Diagnosis

ICD-10 Primary | ICD-10 Secondary

Tissue diagnosis

Date | None ☐

Staging T ☐ N ☐ M ☐ **Grade**

If the member has metastases, please indicate site:

Bone ☐ Liver ☐
Brain ☐ Lung ☐

Specify other:

Previous work up (Please attach copy of report)

X-ray	Yes ☐	No ☐
CT	Yes ☐	No ☐
MRI	Yes ☐	No ☐
Ultrasound	Yes ☐	No ☐

PET CT scan Yes ☐ No ☐
Tumour markers Yes ☐ No ☐

Specify Other

PET Request

- Full body PET CT scan ☐
- Localised PET CT scan ☐
- Gamma PET scan ☐

Intent

- Diagnosis ☐
- Initial staging ☐
- Re-staging ☐
- Monitoring of treatment response ☐

ADDITIONAL PET-CT FORM

Please complete this section for Discovery Health, MSO Administered Schemes, Pharos & Profmed members

1. History of previous PET scan (s)

i. Number of PET scans within last 12 months: _____

ii. Please attach results of previous PET scans Yes ☐ No ☐

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 _____ (name of medical scheme), or its appointed agent, 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:** _____