

PET/CT REFERRAL FORM

Patient Name: _____

Nationality: _____

Place and Date of Birth: _____

Gender: Male / Female

Permanent Address: _____

Mailing Address: _____

Phone Number: _____

E-mail: _____

Relevant Medical History

Diabetes	yes	no	Weight:	_____	kg
Insulin treatment	yes	no	Height:	_____	cm
Oral antidiabetics	yes	no			
Contrast agent allergy	yes	no			
Drug allergy	yes	no			
Active infectious disease	yes	no			
Claustrophobia	yes	no			

Surgery: yes no (when, what kind of) _____

Radiotherapy: yes no (when) _____

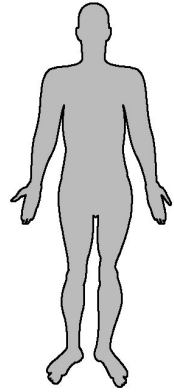
Chemotherapy: yes no (when) _____

Regular medications: _____

Have you ever had PET/CT scan? (date, type) _____

Have you ever had CT scan? (last scan – date, type) _____

Have you ever MR scan? (last scan – date, type) _____

Primary disease(s):	
Clinical question?	Suggested regions to examine:
Short past medical history:	
	

Medicopus Approval (Nonprofit Ltd fills it out!)				
Referral form arrival : _____				
Main indication	Oncology	Neurology	Cardiology	Other
Comment: _____				
The PET/CT scan is performed:		yes	no	
It can be booked from this date: _____				

Date: _____

Patient /Authorized representative

Referral Physician

**The completed referral form should be submitted to the PET Center
via e-mail (medicopus.diagnoztika@sic.medicopus.hu) or post.**