PET / CT Scan Referral Form

Cobalt Imaging Centre
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Cheltenham
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Cobalt
Diagnostic Imaging for Life
Registered Charity No: 1090790

RIS Number:

Referral Date:

Failure to complete ALL relevant sections of this form may result in a delay

PATIENT DETAILS (please print clearly)

Name:	
Date of Birth:	M / F
Address:	
Post Code:	
Telephone No:	Mobile No:
Email address:	
NHS Number:	
MDT Discussion Date (Mandatory):	

REFERRING CONSULTANT DETAILS (please print clearly)

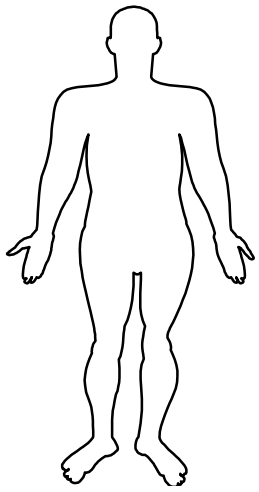
Dr / Mr / Prof. / Ms	First Name:	Surname:
Speciality:		
Hospital:		
Address:		
Post Code:		
Phone No:		Fax No:
Signature:		Bleep No:

FUNDING (please circle as appropriate)

NHS	Private Patient	Self Pay	Other
Private Insurance Company:			
Authorisation Number:			

Previous Imaging	Type:	Location:	Date:

Clinical Information :
(please include copies of recent x-ray / scan reports)



Please indicate site of primary disease or area under consideration

Please Complete Where Relevant

	Type	Cycle Length	Date of Last Treatment	Date of Next Treatment
Surgery				
Chemotherapy				
Radiotherapy				

Is This Patient Diabetic?		Does This Patient Require Sedation?		Could this Patient Present an Infection Risk?	
YES	NO	YES	NO	YES	NO

GP Name:	**PET Centre use only**
Address:	Protocol:
Post Code:	Indication /category:
Telephone No:	Signature: