Patient information (name, surname, DOB):

Telephone number of patient: _____

Fax number of patient: _____

Universitätsklinikum Tübingen

MR / PET – Center

Dept. Nuclear Medicine & Molecular Imaging
Dept. Diagnostic & Interv. Radiology
Otfried-Müller-Str.12 • 72076 Tübingen
Tel: 07071 / 29 - 80544
Fax: 07071 / 29 - 4928

Referring physician:

Request for a MR / PET Examination

Please note:

- ***FASTING REQUIRED FOR CERTAIN EXAMINATIONS (FDG)***
- ***SUFFICIENT HYDRATION (UNSWEETENED TEA OR WATER))***
- ***RECENT CT/MRI-IMAGES & REPORTS REQUIRED!***

Study patient ☐ yes, **Name of study:**_____ ☐ no

Diagnosis and clinical question(s), if applicable histology results:

Surgery	☐ yes, when / localisation	_____	☐ no
Chemo- / Hormontherapy	☐ yes	_____	☐ no
	day of last dosage:	_____ next dosage planned on:	_____
Radiation therapy	☐ yes, when ended	_____	☐ no
Previous Imaging	☐ yes, modality / when / localization	_____	☐ no

The patient has at the time of the examination <u>and</u> for the purpose of the examination the following health insurance status

The name of the public or private health insurance company is required without exception!

- ☐ **Out-patient - insurance:** _____
  - ☐ Private
  - ☐ Pink form from doctor authorizing initial examination/ in-patient status
  - ☐ Paying privately/IGEL
  - ☐ Other _____
- ☐ **In-patient - insurance:** _____
  - ☐ Private
  - ☐ Public Health Insurance
  - ☐ Paying privately
  - ☐ Other _____

Recent creatinine value _____ **mg/dl (normal range:** _____**)**

GFR-MDRD _____ **ml/min/ (normal range:** _____**)** **Height/Weight** ___ _____ cm / ____ kg

Diabetes mellitus?	☐ yes ☐ Type 1 ☐ Type 2	☐ no
Pregnancy?	☐ yes	☐ no
Metal implant / metal parts in the body?	☐ yes <u>please bring a prosthesis implant pass</u>	☐ no
Pace maker / defibrillator?	☐ yes MR-suitable? ☐ ja	☐ no
Artificial heart valve?	☐ yes	☐ no
Surgery on the heart or on the head?	☐ yes	☐ no
Neurostimulator?	☐ yes	☐ no
Allergies / Hypersensitivities?	☐ yes	☐ no
Does the pat. suffer from claustrophobia?	☐ yes ☐ sedating pill sufficient ☐ anesthesia required	☐ no

Preferred appointment date (please give alternatives)

Name, Telephone, Bleeper & Fax of the Referrer: **Date & Signature**

Only to be completed by the PET / MR-Center, please do **<u>not</u>** mark

<u>Indication approved - Radiology:</u>	<u>Indication approved – Nuclear Medicine:</u>
Date: _____ Doctor: _____	Tracer: _____ Radioactivity:_____MBq Date: _____Doctor: _____

Appointment: Date_____ Time_____