Patient:

Universitätsklinikum Tübingen

P E T / C T – Center

Dept. Nuclear medicine and Radiological Diagnostic

Otfried-Müller-Str.14 • 72076 Tübingen

Tel: 29 - 83424

Fax: 29 - 4501

Referrer:

Request for a PET – CT Examination

Please note:

- ***FASTING 12 HOURS BEFORE EXAMINATION***
- ***SUFFICIENT HYDRATES (UNSWEETENED TEA OR WATER)***
- ***ACTUAL CT/MRT-PHOTOS + DIAGNOSIS REQUIRED***

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

Diagnosis and further questions/problems:

Operation	☐ yes, when/body part	_____	☐ no
Chemotherapy	☐ yes, when ended	_____	☐ no
Radiation	☐ yes, when ended	_____	☐ no
Previous CT	☐ yes, when/where	_____	☐ no
Previous PET	☐ yes, when/where	_____	☐ no

Patient has at the time of the examination <u>and</u> for the purpose of the examination the following health insurance status	☐ **Out-patient** ☐ private ☐ Pink form from doctor authorizing initial examination/ in-patient status ☐ Paying personally/IGEL ☐ Other_____	☐ **In-patient** ☐ private ☐ Statutory Health Insurance ☐ Paying personally ☐ Other_____
Height/Weight	_____cm / _____kg	
Actual creatinine value	_____mg/dl	
Pregnancy	☐ yes	☐ no
Diabetes mellitus	☐ yes ☐ Type 1 ☐ Type 2 **Important**: Stop **Metformin** Preparation!	☐ no
Does the patient suffer from claustrophobia?	☐ yes	☐ no
Overactive thyroid gland	☐ yes- Thyroid gland blockade please!	☐ no TSH _____mU/l
Contrast medium allergy	☐ yes	☐ no

Preferred appointment date (please give alternatives)

Name, Telephone, Bleeper and Fax of the referrer — Date, Signature

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

<u>Indication approved - Radiology:</u>	<u>Indication approved - Nuclear medicine:</u>
	Tracer: Radioactivity:_____MBq
Date: Doctor:	Date: Doctor:

Appointment: Date_____ Time_____