KENYATTA UNIVERSITY TEACHING, REFERRAL & RESEARCH HOSPITAL

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Ext: 1555 **Website:** www.kutrrh.go.ke **Email:** imagingcentre@kutrrh.go.ke

DEPARTMENT OF NUCLEAR MEDICINE AND PET-CT

PET-CT REQUEST FORM

Patient Names: .....

Date of Birth: .....

Gender: .....

Hospital Number: .....

Clinical History

Suggested Procedure

- ☐ FDG- PET-CT
- ☐ F18 PSMA
- ☐ F DOPA
- ☐ Other, please specify_____

Does the patient suffer from diabetes?	☐ Yes ☐ No
Is the diabetes controlled by: Diet ☐ Insulin ☐ Tablets	

	CHEMOTHERAPY	RADIOTHERAPY
Type (please tick)		
Cycle length		
Date of last treatment		
Date of next treatment		

Previous surgery ……

Previous Imaging: ☐ PET-CT ☐ SPECT-CT ☐ MRI/CT

Please ensure you attach copy of the latest reports with the request form.

Undertaking by referring Oncologist

I certify that the above requests are medically necessary in care of this patient. All the above particulars furnished are true/correct.

Name: ……. Signature ……. Phone No: ……..

Date: …….

PET-CT request approval (To be approved in Nuclear Medicine and PET-CT Department at KUTRRH)

Name: ……. Signature: ……

Procedure approved? ☐ Yes ☐ No Date: ……