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| **Request for PET/CT scanning****Phone number to schedule an appointment for PET/CT scanning: +420 222 999 046** |
| **Radiopharmaceutical required**  |  |  |  |  |
| **Date of examination**  | **Arrival time at the Proton Therapy Center**  |
| **The referring doctor shall be responsible for properly filling out the request form and informing the patient** |
| **Patient's surname and name** | **National ID number (insurance number)** | **Contact phone number** |
| **Address** | **Code of diagnosis**  |
| **Health insurance company** | **Self-funding**  | **Height** | **Weight** |
| **Illness and its course / brief summary** |
| **Basic diagnosis and summary (specify in detail)**  |
| **Treatment – Chemotherapy** |   | **last treatment date**  |
| **Treatment – Radiotherapy** |  | **last treatment date** |
| **Treatment – hormonal** |  | **last treatment date** |
| **Surgical procedures related to diagnosis** | **when** |
| **Inflammatory complications, if any** | **other** |
| **Previous examination**  |
| **Where**  | **When**  |
| **Notice for doctors at the Department of Nuclear Medicine (Expected benefit of the examination)**  |
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| **Allergies to:** |
| **Diabetes** |  | **Current blood glucose level:**  |
| **Renal insufficiency** |  | **Current creatinine level:**  |
| **Pregnancy** |  | **Breastfeeding** |  |
| **The examination is urgent** |  | **Immobility** |  |
| **Examination under anaesthesia** |  | **Does the patient need oxygen??** |  |

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| **Information for doctors** |
| * A PET/CT scan should be performed at least 3-4 weeks apart from chemotherapy and 3 months apart from radiotherapy to evaluate the irradiated area. The longer the time intervals, the greater the reliability of PET scanning.
* The iodine contained in the contrast agent makes it impossible to use thyroid scintigraphy or radioiodine treatment within the next 2 months.
* It is necessary for the patient to cooperate and be able to remain completely still during the examination.
* Examination of children according to their ability to cooperate, possible from about 4 years of age, general anaesthesia may be used for children older than 2 years and weighing more than 10 kg.
* In a hospitalized patient with infusion therapy, parenteral nutrition should be discontinued at least 4 hours before the exam; it is advisable to continue hydrating the patient with crystalline solutions, but without glucose and insulin.
* Pregnancy is a relative contraindication to PET/CT scanning.
* For immobile patients, it is necessary to provide an accompanying person for the PET/CT, who will remain with the patient during the entire stay at the Department of Nuclear Medicine.
* When transporting a patient by ambulance, it is necessary to issue a request form for the transport as well as for the return journey.
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| **Patient instructions** |
| * The patient will come for a PET/CT scan to the Proton Therapy Center, which is located on the grounds of the Bulovka University Hospital, address: Budínova 1a, Praha 8, Czech Republic.
* The patient must have their phone switched on so that they can be contacted in case of operational problems.
* The patient should arrive on time, after having observed the required preparations before the scanning. Our staff will contact each patient in advance regarding the scan.
* The duration of the patient's stay on the site will be about 2 to 4 hours, exceptionally longer (depending on the type of procedure).
* Diabetics should not take insulin in the morning (they should bring food and insulin with them).
* For reasons of radiation protection, patients should limit close contact with children and pregnant women as much as possible 24 hours after the administration of the radiopharmaceutical. For the same reason, we also ask patients not to bring children or pregnant women as accompanying persons to the scanning.
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| **Referring healthcare facility** |
| **Referring healthcare facility** | **Name of the referring doctor** |
| **Site ID of the facility** *(for Czech Healthcare facility)* *(an 8-digit number on the left of the stamp)* | **Speciality**  |
| **Contact phone number** | **E-mail address** |
|  |
| **Date**  | **Stamp and signature of the referring doctor**  |

*Send the original copy with the doctor's stamp and signature to the PTC or the patient can hand it over in person.*