

Department of Molecular Imaging and Therapy

Telephone: (03) 9496 5718 Facsimile: (03) 9457 6605

COGNITIVE DECLINE BRAIN PET REOUEST

When is scan required:	Date of Next	Review with specialis	st:		
Patient Details	Patient Co	ntact Details			
Surname	Home Phone Number				
First Name		Mobile Phone Number			
Date of Birth		Email address			
Austin UR	 Al	Alternative Contact person			
Address		Number			
Suburb					
Gender Male ☐ Female ☐ Claustrop Diabetes	hobia _{Yes} Yes	No ☐ Conces	Overseas Patient ssion/Pension Card	Yes No No Yes No No	
,	¹⁸ F-AV133 VN racts a charge)	1AT *	18F-NAV469 *(Attracts a charge)	94 Amyloid *	
	<u> </u>		, ,		
Clinical Information and Correlative Imaging				x	
Pre-scan diagnosis: (Tick one or more) Possi Normal □		le Investiga	ntions performed:	ation	
Depression / Anxiety	=		☐ Neuropsycho		
Minimal Cognitive Impairment (MCI)			СТ		
Alzheimer's Disease (AD) Front-temporal Dementia (FTD)			☐ MRI ☐ Routine Blood	d Screen	
Diffuse Lewy Body (DLB)			Other:	Joreen	
Vascular Dementia					
Mixed AD and Vascular Dementia					
Other Clinical History					
Cililical History					
Specialist Details & Report Distribution (Must	be signed by a Cor	nsultant at the time	of booking)		
Referring Specialist		Provider No.			
Mobile		 Signature			
Email address		 Date			
Preferred mechanism of electronic transfer of report:	HealthLink 🗆	 Medinexus □	Other:		
Additional copy of report to:					
Email address					
Preferred mechanism of electronic transfer of report:	HealthLink 🗆	Medinexus 🗆	Other:		

Patients are free to take their request to a diagnostic imaging provider of their choice. Please discuss with your doctor first.