

COGNITIVE DECLINE REFERRAL FORM FOR SPECT/ PET SCAN

Note: SPECT brain scan will be performed prior to FDG PET. If SPECT result is diagnostic, FDG PET may not be performed.

When is scan required: _____ Date of Next Review with specialist: _____

Patient Details

Patient Contact Details

Surname _____	Home Phone Number _____
First Name _____	Mobile Phone Number _____
Date of Birth _____	Email address _____
Austin UR _____	Alternative Contact person _____
Address _____	Number _____
Suburb _____	
Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	Claustrophobia Yes <input type="checkbox"/> No <input type="checkbox"/>
	Overseas Patient Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes Yes <input type="checkbox"/> No <input type="checkbox"/>	Concession/Pension Card Yes <input type="checkbox"/> No <input type="checkbox"/>

Study: SPECT/FDG PET ¹⁸F-AV133 VMAT * ¹⁸F-NAV4694 Amyloid *
 FDG PET only * *(Attracts a charge)

Clinical Information and Correlative Imaging – Please indicate by a tick in the appropriate box

Pre-scan diagnosis: (Tick one or more)	Possible	Probable	Investigations performed:
Normal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Clinical Evaluation
Depression / Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neuropsychologist
Minimal Cognitive Impairment (MCI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> CT
Alzheimer's Disease (AD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> MRI
Front-temporal Dementia (FTD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Routine Blood Screen
Diffuse Lewy Body (DLB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other:
Vascular Dementia	<input type="checkbox"/>	<input type="checkbox"/>	
Mixed AD and Vascular Dementia	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

Clinical History

Specialist Details & Report Distribution (Must be signed by a Consultant 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 referral to a diagnostic imaging provider of their choice. Please discuss with your doctor first.

Prof Andrew Scott MD, FRACP, DDU; Prof Christopher Rowe MD, FRACP; Dr Sam Berlangieri FRACP; Associate Prof Sze Ting Lee PhD, FRACP; Dr Aurora Poon FRACP; Dr Andrew Tauro FRACP; Dr Raef Boktor MD, FRACP, DDU; Dr Robin Low FRACP, DDU; Associate Prof Eddie Lau FRANCR.