

## MOLECULAR IMAGING AND THERAPY REFERRAL FORM

### Nuclear Medicine Procedures

When is scan required: \_\_\_\_\_

Date of next review: \_\_\_\_\_

#### 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 \_\_\_\_\_

Phone number \_\_\_\_\_

Suburb \_\_\_\_\_

#### Patient status:

Gender  Male  Female

Public  DVA  
 Private  TAC  
 Overseas patient  Workcare

#### Referral Information (This form is not to be used for PET scan requests)

Examination required: \_\_\_\_\_

Clinical notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Patient mobility requirements:

Weight over 150kg?

Requires a hoist lift?

#### Requesting Doctor & Report Distribution

Referring Doctor \_\_\_\_\_

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.  
Referral forms may be downloaded from <http://www.austin.org.au> or the Austin HUB ([http://hub/Assets/Files/NM\\_referral\\_form.pdf](http://hub/Assets/Files/NM_referral_form.pdf))