Austin HEALTH
Department of Molecular Imaging and Therapy

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

Austin Hospital
Level 1, Harold Stokes Building
Burgundy Street
Victoria 3084

COGNITIVE DECLINE REFERRAL FORM FOR PET SCANS

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

Patient Details

Surname _____
First Name _____
Date of Birth _____
Austin UR _____
Address _____
Suburb _____
Gender Male ☐ Female ☐

Patient Contact Details

Home Phone Number _____
Mobile Phone Number _____
Email address _____
Alternative Contact person _____
Number _____

Claustrophobia Yes ☐ No ☐
Diabetes Yes ☐ No ☐
Overseas Patient Yes ☐ No ☐
Concession/Pension Card Yes ☐ No ☐

Study: ☐ FDG PET ☐ ^{18}F-AV133 VMAT * ☐ ^{18}F-NAV4694 Amyloid *

*(Attracts a charge) *(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**
Normal	☐	☐
Depression / Anxiety	☐	☐
Minimal Cognitive Impairment (MCI)	☐	☐
Alzheimer's Disease (AD)	☐	☐
Front-temporal Dementia (FTD)	☐	☐
Diffuse Lewy Body (DLB)	☐	☐
Vascular Dementia	☐	☐
Mixed AD and Vascular Dementia	☐	☐
Other	☐	☐

Investigations performed:

☐ Clinical Evaluation
☐ Neuropsychologist
☐ CT
☐ MRI
☐ Routine Blood Screen
☐ Other:

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.

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