Austin HEALTH
Department of Molecular Imaging and Therapy

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EPILEPSY BRAIN PET SCAN REQUEST

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 ☐
Inpatient Yes ☐ No ☐

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 Yes ☐ No ☐

Clinical Notes – Please indicate by a tick ☑ in the appropriate box

Investigations performed:

- ☐ Clinical evaluation
- ☐ EEG
- ☐ Video EEG
- ☐ MRI
- ☐ Ictal SPECT
- ☐ Invasive monitoring

Clinical Notes:

Results of standard investigations prior to PET

Epilepsy Type:
- ☐ Temporal Lobe
- ☐ Extra-Temporal
- ☐ Uncertain

Lateralised:
- ☐ Left
- ☐ Right
- ☐ Not lateralised

Site:
- ☐ Temporal
- ☐ Parietal
- ☐ Occipital
- ☐ Frontal
- ☐ Insula
- ☐ Not localised

Location Confidence:
- ☐ Possible
- ☐ Probable
- ☐ Very Probable
  (sufficient for surgical decision)

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

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