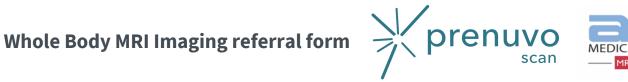
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Patient Information	
First name	Last name
Date of Birth	Male Female
Address	
City and Province	Postal Code
Tel Home	Cell
Email	Insurance Information / PHN

Referring Medical Professional Information

First name	Last name	Stamp / Contact information
Specialty / Profession	License ID number	
Signature		
Date		

Scan			Safety Checklist		
Torso Head and Torso Whole Body Reason for scan (mark below to avoid assessing GST)			Does the patient have a cardiac pacemaker? Does the patient have an intracranial aneurysm clip or	Yes	Yes No
	Family history of cancer or disease Previous cancer diagnosis Genetic risk of cancer or disease	 Prior surgery or organ transplant Over 50, thus increased disease risk Persistently feel unwell or have pain with no 	a programmable ventriculoperitonel shunt? Is there a risk of metallic foreign body in the patient's eye? (eg. metal worker) Has the patient had a cochlear implant or neurotransmitter?		
Any	Fear of cancer or major illness Relevant Patient History	explanation	Has the patient had a surgery in the last 8 weeks? Does the patient have a known or suspected communicable disease?		