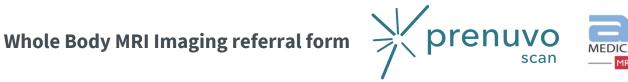
. . .





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	<ul> <li>Prior surgery or organ transplant</li> <li>Over 50, thus increased disease risk</li> <li>Persistently feel unwell or have pain with no</li> </ul>	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?		