

Great-West Life PET/CT Centre

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NEUROLOGY: Physician Referral Form

Patient Name _____

Birth date _____ **PHIN** _____
(dd/mmm/yy)

HSC# _____

Home # _____ **Cell #** _____

Address _____

Weight _____ **kg** **Height** _____ **cm**

1. Relevant History, clinical diagnosis **OR** **Recent clinic / assessment letter attached:**

2. INDICATION

DEMENTIA

Clinical Disorder: Mild cognitive impairment
 Dementia mild moderate severe

Year of onset of symptoms: _____

Presumptive diagnosis: Alzheimer's Disease Other: _____

Neuropsychological Testing (Mini mental status exam (MMSE) or similar test)- ATTACH REPORTS

Functional Status: (Attach test reports, if applicable) _____

EPILEPSY

Year of onset: _____ Seizure frequency: _____


EEG findings: _____

Suspected location: _____

OTHER INDICATIONS: _____

3. Please attach relevant imaging reports (PET, MRI, CT etc.)

**COMPLETE THIS SECTION IF SCAN BEING
DONE AS PART OF A RESEARCH STUDY**



Research

Study RRC# or RI #

Subject ID #

Billing (check one):

Manitoba Health
(i.e., Standard of Care Imaging)

Research
(above-standard-of-care imaging)

Measurements:

Required OR

Not Required

4. **CURRENT MEDICATIONS:** _____

5. Can patient manage with minimal assistance and look after personal needs? Yes No
 Can patient lie supine for twenty minutes? Yes No
 Can patient provide informed consent for the procedure? Yes No

6. **DIABETES:** No Diet only Medication-controlled Insulin-controlled
 Physician Caring for Diabetes (please print) _____

Referring Physician Name: _____
 (please print)

Phone or Pager: _____

Referring Physician Signature: _____

Date: _____
 (dd mmm yyyy)

-----NUCLEAR MEDICINE USE ONLY-----						
<input type="checkbox"/> MD APPROVED				INITIALS _____		
PRIORITY <input type="checkbox"/> 1			<input type="checkbox"/> 2		<input type="checkbox"/> 3	
PRODUCT	ACTIVITY / AMOUNT	ROUTE	INJ. SITE	DATE	TIME	TECH
18F - FDG	MBq	I.V.			h	