

COGNITIVE DECLINE BRAIN PET REQUEST

When is scan required: _____

Date of Next Review with specialist: _____

Patient Details

Patient Contact Details

Surname _____

Home Phone Number _____

First Name _____

Mobile Phone Number _____

Date of Birth _____

Email address _____

Austin UR _____

Alternative Contact person _____

Address _____

Number _____

Suburb _____

Gender Male Female Claustrophobia Yes No

Overseas Patient Yes No

Diabetes Yes No

Concession/Pension Card Yes No

Study: FDG PET ¹⁸F-AV133 VMAT * ¹⁸F-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

Investigations performed:

- | | | |
|------------------------------------|--------------------------|--------------------------|
| Normal | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression / Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| Minimal Cognitive Impairment (MCI) | <input type="checkbox"/> | <input type="checkbox"/> |
| Alzheimer’s Disease (AD) | <input type="checkbox"/> | <input type="checkbox"/> |
| Front-temporal Dementia (FTD) | <input type="checkbox"/> | <input type="checkbox"/> |
| Diffuse Lewy Body (DLB) | <input type="checkbox"/> | <input type="checkbox"/> |
| Vascular Dementia | <input type="checkbox"/> | <input type="checkbox"/> |
| Mixed AD and Vascular Dementia | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> |

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

Prof Andrew Scott MD, FRACP, FAHMS; Prof Christopher Rowe MD, FRACP; Dr Sam Berlangieri FRACP; Associate Prof Sze Ting Lee PhD, FRACP; Dr Aurora Poon FRACP; Dr Andrew Tauro FRACP; Dr Raef Boktor MD, FRACP, DDU; Dr Robin Low FRACP, DDU; Associate Prof Eddie Lau FRANCR; Dr Reza Garzan FRACP.