BLACKROCK HEALTH
BLACKROCK CLINIC

PSMA PET/CT Request Form

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Email: nuclear.medicine@blackrock-clinic.com
PET/CT Department

Patient Details
(Please Print)

Name: _____ **Date of Birth**:____/____/____

Address: _____

Mobile Phone: _____ Home Phone: _____

IN-PATIENT: No ☐ Yes ☐ Hospital _____ Ward _____

Mobility: Mobile ☐ Needs assistance ☐ **Weight:** _____ **Height:** _____

Order Number: _____ OR **Private Health Insurance:** _____

Priority of Referral

Routine ☐ Urgent ☐ Planned Scan (please specify date) ☐ _____

Indication

Diagnosis ☐ Response ☐ Recurrence Detection ☐ Staging ☐ Restaging ☐

Summary of Clinical History

Clinical information:

_____

_____

_____

_____

Questions to be answered:

_____

_____

Is the patient diabetic? Yes ☐ No ☐ Type 1 ☐ Type 2 ☐

Infection Control Issues: Yes ☐ No ☐ If yes, details _____

Date Last: Surgery: _____ Chemotherapy: _____ Radiation Therapy: _____

Imaging History

Previous PET/CT Yes ☐ No ☐ Reports Included ☐ Images Included ☐

Previous CT/ MRI Yes ☐ No ☐ Reports Included ☐ Images Included ☐

Referrer Details

Referrer Declaration

The requested PSMA PET/CT scan will involve the use of the radiopharmaceutical ^{18}F-PSMA-1007 (Curium Pharma Ireland). I understand ^{18}F-PSMA-1007 does not hold HPRA Product Authorisation and that its use is entirely the responsibility of the signing physician. I recognise that there is no licensed alternative available and by signing below I am assuming responsibility for the administration of ^{18}F-PSMA-1007 to the above patient.

Consultant Name: _____ Consultant Signature: _____
(BLOCK CAPITALS)

Consultant IMC Number:_____ Secretary's Contact Number: _____

Date of Request:_____ **Referring Hospital:**_____