CLINICAL SERVICES
CENTRE FOR DIAGNOSTIC NUCLEAR IMAGING
(UPM/PPDN/CS/REQUESTFORM/BR01)

TEL : 0389471644 FAX : 0389472775 EMAIL : ppdn@upm.edu.my

REQUEST FORM

(To be filled by the referring doctor)

EXAMINATION REQUIRED :

- ☐ PET/CT PART :
- ☐ CT SCAN
- ☐ MRI
- ☐ ULTRASOUND

PATIENT DETAILS

Name :
I.C No :
Age :
Sex :
Race :

CLINICAL STATUS

	Yes	No
Allergic to contrast media		
Diabetic		
Claustrophobic		
Pregnant		
Breastfeeding		

Date of **LMP :**

Weight :
Height :

Mobile Phone :
Home Phone :

CLINICAL DIAGNOSIS

RECENT CHEMOTHERAPY/RADIOTHERAPY: WHEN: _____

RECENT CORRELATIVE IMAGING

- ☐ CT Date :
- ☐ MRI Date :
- ☐ PET CT Date :
- ☐ Others :

RELEVANT FINDINGS

REFERRING DOCTOR

Name :

Signature & Stamp :
Date :
Phone :

CLINICAL SERVICES
CENTRE FOR DIAGNOSTIC NUCLEAR IMAGING
DOCUMENT CODE: UPM/PPDN/CS/CONSENT/FORM05
TEL. NO.: 0389471642/1643/1644 FAX NO.: 0389472775

CONSENT FORM

PATIENT DETAILS *(Patient sticker)*

Patient need to be fasting 6 hours prior to PET CT / CT SCAN examination.
Please inform Doctor, Radiographer or Nurse if you are:

		Yes	No
Pregnant or suspected pregnancy			
Last Menstrual Period	: _____		
Allergic to contrast media			
Allergic to any medication or seafood			
Diabetic/multiple myeloma/Phaechromytoma			
Blood pressure	: _____		
Asthmatic			
Chronic kidney disease			
Serum Cretinine	: _____		
Buse	: _____		
Age over 60 years			

If you have any allergic or asthmatic you should take:
Tablet Prednisolone 40mg 12 hours before examination
and
Tablet Prednisolone 40mg 2 hours prior to examination
(Adult dose only. For children need to be advise by Doctor)

I _____ I/C No. / Passport _____

Has been explained about procedure _____

and understand about the complication described by _____

I certify and understand that I will comply with all rules and regulations provided.

I authorize the Diagnostic Nuclear Imaging Center to conduct this examination.

I allow the analysis and research conducted on my tissues and body fluids for research and disease detection.

I also allow images results from this scan to be used for the purpose of teaching and research.

Patient / Relative	Doctor	Witness
Name:		

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	PERKHIDMATAN KLINIKAL **PUSAT PENGIMEJAN DIAGNOSTIK NUKLEAR** **DOCUMENT CODE: UPM/PPDN/CS/CONSENT/FORM05** **TEL. NO.: 0389471642/1643/1644 FAX NO.: 0389472775**
	BORANG KEBENARAN

MAKLUMAT PESAKIT *(Pelekat Pesakit)*

Pesakit perlu berpuasa 6 jam sebelum pemeriksaan PET CT/CT Scan.
Sila beritahu Juru X-Ray/Pegawai/Jururawat yang bertugas sekiranya:

	Ya	**Tidak**
Mengandung atau disyaki mengandung		
Hari pertama haid terakhir : _____		
Alahan pada media kontras		
Alahan pada ubat-ubatan/makanan laut		
Menghidap kencing manis/multiple myeloma/Phaechromytoma		
Tekanan darah : _____		
Menghidap asma/lelah		
Menghidap sakit buah pinggang		
Serum Kretinin : _____		
Buse : _____		
Umur melebihi 60 tahun		

Arahan sekiranya terdapat sebarang alahan dan asma/lelah anda perlulah mengambil:
Tablet Prednisolone 40mg 12 jam sebelum pemeriksaan
dan
Tablet Prednisolone 40mg 2 jam sebelum pemeriksaan dijalankan
(Dos ini hanya untuk orang dewasa. Kanak-kanak perlu mendapatkan nasihat doktor)

Saya _____ No. Kad Pengenalan _____

telah diberitahu tentang prosedur pemeriksaan _____

dan faham tentang kompilasi yang diterangkan oleh _____

Saya memperakui bahawasanya saya memahami dan mematuhi segala arahan dan peraturan yang diberikan.
Saya membenarkan analisa dan kajiselidik dijalankan ke atas tisu dan cecair badan saya bagi tujuan penyelidikan dan pengesanan penyakit.
Saya juga membenarkan imej pemeriksaan ini digunapakai bagi tujuan pengajaran dan penyelidikan.

Pesakit / Penjaga	Doktor	Saksi
Nama:		

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