



**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 :

| | | |
|--------------------------|------------|--------|
| <input type="checkbox"/> | PET/CT | PART : |
| <input type="checkbox"/> | CT SCAN | |
| <input type="checkbox"/> | MRI | |
| <input type="checkbox"/> | ULTRASOUND | |

PATIENT DETAILS

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

CLINICAL STATUS

| | | |
|----------------------------|--------------------------|--------------------------|
| | Yes | No |
| Allergic to contrast media | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetic | <input type="checkbox"/> | <input type="checkbox"/> |
| Claustrophobic | <input type="checkbox"/> | <input type="checkbox"/> |
| Pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| Breastfeeding | <input type="checkbox"/> | <input type="checkbox"/> |
| Date of LMP : | | |

Weight :
Height :

Mobile Phone :
Home Phone :

CLINICAL DIAGNOSIS

RECENT CHEMOTHERAPY/RADIOTHERAPY: _____ WHEN: _____

RECENT CORRELATIVE IMAGING

RELEVANT FINDINGS

| | | |
|--------------------------|----------|--------|
| <input type="checkbox"/> | CT | Date : |
| <input type="checkbox"/> | MRI | Date : |
| <input type="checkbox"/> | PET CT | Date : |
| <input type="checkbox"/> | Others : | |

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 | <input type="checkbox"/> | <input type="checkbox"/> |
| Last Menstrual Period : _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergic to contrast media | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergic to any medication or seafood | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetic/multiple myeloma/Phaeochromytoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood pressure : _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthmatic | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic kidney disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Serum Cretinine : _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Buse : _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Age over 60 years | <input type="checkbox"/> | <input type="checkbox"/> |

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
 Name:

 Doctor

 Witness

Reviewed no. : 01
 Issued no. : 01
 Effective date : 07/08/2014



PERKHIDMATAN KLINIKAL
PUSAT PENGIMEJAN DIAGNOSTIK NUKLEAR
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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/Phaeochromytoma | | |
| 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
Nama:

Doktor

Saksi

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