**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 :