

# THE HARLEY STREET CLINIC

## MOLECULAR IMAGING CENTRE

154 Harley Street, London, W1G 7LJ

Booking Phone: 020 7725 6800 / 020 7323 0365

Booking Fax: 020 7725 6868 / 020 7323 0340

### Request Form

Please complete all sections of this request form and sign. Fax form or post to:  
Molecular Imaging Centre, 154 Harley Street, London, W1G 7LJ. Fax: 020 7725 6868 / 020 7323 0340

#### Patient Details

Name: \_\_\_\_\_ Male /Female: \_\_\_\_\_  
 Address: \_\_\_\_\_ Start date of Last Menstrual Period (if applicable): \_\_\_\_\_  
 Patient arrival: Trolley  Wheelchair  Walking   
 Funding: NHS  Self-funded  Private Patient  Embassy   
 Patient's insurance company: \_\_\_\_\_  
 Postcode: \_\_\_\_\_ Membership number: \_\_\_\_\_  
 Tel: \_\_\_\_\_ Mobile: \_\_\_\_\_ Pre-authorisation number (if known): \_\_\_\_\_  
 Email: \_\_\_\_\_ *Please note: Uninsured patients or patients without pre-authorisation are required to pay on the day of their appointment.*  
 Date of Birth: \_\_\_\_\_

#### Type of Examination Required

PET/CT with CT scan for anatomical fusion only  Nuclear Medicine   
 PET/CT PLUS Full Diagnostic CT  Details: \_\_\_\_\_

#### Reason for Referral

Please state the patient's condition, reason for requesting a scan and how it may affect patient's management:

#### Relevant Previous Medical History

(including surgery / medications)

Is the patient diabetic? YES (diet / oral medication / insulin) / NO

Does the patient have any allergies? YES / NO (If yes, please specify):

Is the patient an infection risk? YES / NO (If yes, please provide details):

Details of most recent imaging:

(Please make available all relevant patient imaging)

Chemotherapy	Type	Commenced:	Ended:
Radiotherapy	Field:	Commenced:	Ended:

#### Referring Clinician's Details

IR(ME)R 2000 Regulations require this form to be signed by the referring Clinician

Hospital (if applicable):  
Address:

Consultants name:

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Email: \_\_\_\_\_