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 :**

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 :