

Appointment date: / /

Appointment time:

Please bring your Medicare card, previous x-rays and scans.

Patient details

Name: _____ DOB: / /

Phone: _____

Procedure Requested: *Please tick or write below*

<input type="checkbox"/> Bone scan +/- SPECT-CT	<input type="checkbox"/> DEXA BMD
<input type="checkbox"/> Thyroid	<input type="checkbox"/> DEXA Body Composition
<input type="checkbox"/> Parathyroid	<input type="checkbox"/> Biliary scan
<input type="checkbox"/> Exercise myocardial perfusion	<input type="checkbox"/> Cerebral perfusion
<input type="checkbox"/> Persantin myocardial	<input type="checkbox"/> Gastric emptying
<input type="checkbox"/> Gated heart pool scan	<input type="checkbox"/> Renal scan (DTPA / MAG3 / DMSA)
<input type="checkbox"/> Lung scan (V/Q)	<input type="checkbox"/> Reflux scan
<input type="checkbox"/> Others:	

Clinical notes

Referring Doctor These sections MUST be completed	
Name:	Provider No:
Address:	Speciality:
	Phone:
	Fax:
	Email:
Signature:	Date:



PATIENT INSTRUCTIONS

You must inform staff if you are **pregnant** (or if there is any chance that you may be pregnant) or if you are breast feeding.

Scan preparation (if applicable):

- **Myocardial Perfusion Scan:** This test requires you to fast from midnight. Plain water is allowed. **Do not have caffeine (e.g. coffee, tea, coca-cola, chocolate) for 24 hours prior to your test.** Please consult your doctor regarding medications before the test.
- **Biliary Scan:** Please do not eat or drink for 6 hours prior to your test. If you are taking pain killers, please contact us for specific instructions.
- **Bone and Lung (V/Q) Scans:** No Preparation.
- **Colonic Transit:** This test is done over 5 days and you will need to attend our practice once a day for images (15 mins). Fasting from midnight. Please consult with reception regarding medication (certain medications might interfere with this test).
- **Renal Scans:** There are 3 different types of this test (depending on what your doctor is looking for) therefore when booking in, we require a copy of the referral.

All other tests: Please contact us for specific instructions.

We require 24hrs notice for any cancellations.



Ground Floor, 13 - 15 Silver Street, Randwick NSW 2031

Ph: 9197 8000 Fax: 9197 8029

You doctor has recommended you use Spectrum Nuclear Imaging.
You may choose another provider but please discuss with your doctor first

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