



Conventional Nuclear Medicine Request Form

Patient Details		Referring doctor	
Name: _____		Name: _____	
Surname: _____		Surname: _____	
Med Aid: _____		Practice No: _____	
Med Aid No: _____		Contact No: _____	
Contact No: _____ Alt Contact No: _____		Email: _____	
Email: _____		Signature: _____ Date: _____	
Tick	Please tick the scan required:	Diagnosis:	
	Oncology:		
	Bone scintigraphy		
	¹³¹ I thyroid wholebody scan		
	¹²³ I thyroid wholebody scan		
	^{99m} TcMIBI thyroid scintigraphy		
	^{99m} Tc Tektrotyd scan		
	¹²³ I MIBG scan		
	^{99m} TcPSMA scintigraphy		
	Sentinel lymph node mapping		
	¹³¹ I wholebody scan post ¹³¹ I therapy		
	Infection imaging:	ICD 10:	
	^{99m} TcHMPAO (labeled white blood cell) scintigraphy		
	Bone scan		
	Cardiology:	History including indication for the scan:	
	MUGA scan		
	Myocardial perfusion scintigraphy (exercise)		
	Myocardial perfusion scintigraphy (pharmacological)		
	Amyloid imaging		
	Neurology:		
	Brain perfusion scintigraphy		
	Movement disorder imaging (^{99m} TcTRODAT scan)		
	Endocrine:		
	Thyroid scintigraphy		
	Parathyroid scintigraphy (^{99m} TcMIBI scan)		
	Pulmonary:		
	VQ scan		
	Quantitative lung perfusion scan		
	Lymphatic system:		
	Lymphoscintigraphy		
	Musculoskeletal system/ Rheumatology:		
	Bone scintigraphy		
	Gastrointestinal system:		
	Milk scan		
	Gastric emptying		
	GIT bleed study		
	Denatured RBC scan		
	Hepatobiliary system:		
	HIDA scan		
	Renal system:	Previous Imaging	
	^{99m} TcMAG 3 scintigraphy		
	^{99m} TcDTPA scintigraphy		
	^{99m} TcDMSA scan		
	Other:		