



Government of **Western Australia**
Department of Health



NEUROLOGY REFERRAL FORM FOR PET SCAN
The Western Australian Positron Emission Tomography Service
Sir Charles Gairdner Hospital

Scan	Done	Findings
CT/MRI	<input type="checkbox"/> Yes <input type="checkbox"/> No	
EEG	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Video EEG	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ictal SPECT	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	

B. Cognitive Decline Yes No

Pre-Scan Diagnosis: <i>(Tick one or more)</i>	Possible	Probable	Comments
Depression/anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
Minimal Cognitive Impairment (MCI)	<input type="checkbox"/>	<input type="checkbox"/>	
Alzheimer's Disease (AD)	<input type="checkbox"/>	<input type="checkbox"/>	
Fronto-temporal Dementia (FTD)	<input type="checkbox"/>	<input type="checkbox"/>	
Diffuse Lewy Body (DEB)	<input type="checkbox"/>	<input type="checkbox"/>	
Vascular Dementia	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

Additional Notes: _____

Scan	Done	Findings
CT/MRI	<input type="checkbox"/> Yes <input type="checkbox"/> No	
SPECT	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Neuropsychology Opinion	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	

C. Other Yes No

Clinical Details: _____

Scan	Done	Findings
CT/MRI	<input type="checkbox"/> Yes <input type="checkbox"/> No	
SPECT	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	