SIR CHARLES GAIRDNER HOSPITAL URN: URN: URN: Sumame: DEPARTMENT OF NUCLEAR MEDICINE AND WA PET SERVICE CHECKLIST Sumame: Forename: Forename: Gender: DoB: Commercian Commercian Commercian Commercian Proposed scan:	er 10 mmols
DEPARTMENT OF NUCLEAR MEDICINE AND WA PET SERVICE CHECKLIST Forename: Gender:	er 10 mmols
Proposed scan:	er 10 mmols
Fasted: yes no Time: IV access: yes no Type: Weight: Height: Height: Caffeine free: yes no Time: Diabetic: yes no BSL: notify if over Claustrophobic: yes no Pain scale: Allergies:	er 10 mmols
IV access: ges no Type: Weight: Height: Height: Caffeine free: ges no Time: Diabetic: ges no BSL: notify if over Claustrophobic: ges no Pain scale: Time: Allergies: Image: Image: Image: Image:	er 10 mmols
Weight: Height: Caffeine free: yes no Diabetic: yes no BSL: notify if over Claustrophobic: yes no Pre med given: Time: Allergies: Image:	er 10 mmols
Caffeine free: yes no Time: Diabetic: yes no BSL:notify if over Claustrophobic: yes no Pain scale: Pre med given: Time: Allergies:	er 10 mmols
Diabetic: yes no BSL:notify if over Claustrophobic: yes no Pain scale: Pre med given: Time: Allergies:	er 10 mmols
Claustrophobic: yes no Pain scale: Pre med given: Time: Allergies: Image:	
Pre med given: Time: Allergies: Image: Imag	
Allergies:	
Allergies: Allergy Sticke	
	1
Pulse: BP: Resps:	
Time of last void: Incontinence pad changed: D	yes 🗆 no
Special care Physical impairments Prostheses se	ent with pt
O2 □ Yes □ No Visual □ Yes □ No Z/Frame □	∃Yes □ no
IV □ Yes □ No Blind □ Yes □ No Eyeglasses □	∃Yes □ no
IDC	∃Yes □ no
Drain 🗆 Yes 🗆 No Continent 🗆 Yes 🗆 No Hearing aid 🗆]Yes □ no
Other:	
Precautions Yes No	
Pregnant 🛛 Yes 🗆 No	
This form MUST be completed and sent with patient for all Nuclear Medicine and Nurse:	PET Scans
Print name signatu	ure
Ward:	

Treatment:									
Time	Р	R	Sats	Вр	Pain Score	Sedation Score	Comments		