San RADIOLOGY AND NUCLEAR MEDICINE

Appointments: 02 9480 9840 | Enquiries: 02 9480 9850
Radiology/MRI Level 3, Tulloch Building
Fax: 02 9480 9845
Nuclear Medicine/PET-CT Level 3, San Clinic
Fax: 02 9480 8755

PROSTATE IMAGING REQUEST

Patient Name: ..... D.O.B: .....

Address: ..... Postcode: .....

Phone: ..... Mobile: ..... MRN: .....

Is this patient part of a Clinical Trial? ☐ Yes ☐ No. If yes, Name of trial _____

PROSTATE IMAGING EXAMINATIONS (Medicare eligibility criteria / indications for MRI are provided on the back of this form)

MRI:

- ☐ mpMRI Prostate [MBS Item 63541 - Diagnosis]
- ☐ mpMRI Prostate [MBS Item 63543 - Surveillance]
- ☐ mpMRI Prostate [Non-Medicare Eligible]
- ☐ MRI Prostate - RT Planning Protocol Only [Non-Medicare Eligible]
- ☐ MRI Prostate - Koelis Work-Up [Non-Medicare Eligible]

Which Lesions? _____

PET or PET-CT:

- ☐ PET - Ga-68 PSMA
- ☐ PET - F-18 PSMA/PSR
- ☐ PET - F-18 FDG

☐ with Diagnostic CT - as per protocol or specify region: _____

OTHER IMAGING EXAMINATIONS:

- ☐ NM TC-99m Whole Body Bone Scan (+/- SPECT-CT)
- ☐ NM _____
- ☐ CT _____
- ☐ US _____
- ☐ OTHER _____

1. Previous Contrast Allergy? ☐ YES ☐ NO
2. Is the Patient Diabetic? ☐ YES ☐ NO
3. Able to have Buscopan? ☐ YES ☐ NO
4. Current Creatinine: _____ Current eGFR: _____

Date: ____ /____ /____

CLINICAL INFORMATION

REASON FOR REQUEST:

- ☐ Detection
- ☐ Staging
- ☐ Active Surveillance
- ☐ Suspected Recurrence (Post Treatment)
- ☐ +ve DRE Finding

PSA INFORMATION:

Current PSA: _____ (ng/mL) Date: ____ /____ /____

PSA Trend: _____

BIOPSY INFORMATION:

Gleason Score: [ ] + [ ] = [ ]

Bx Results: ☐ +ve ☐ -ve ☐ Indeterminate

Diagnosis if +ve: _____

Date of Bx: ____ /____ /____

Pathology Provider: _____

PREVIOUS EXAMINATIONS:

- ☐ MRI Provider: _____ Date: ____ /____ /____
- ☐ PET-PSMA Provider: _____ Date: ____ /____ /____
- ☐ CT Provider: _____ Date: ____ /____ /____

TREATMENT:

- ☐ Surgery: _____ Date: ____ /____ /____
- ☐ RT: _____ Date: ____ /____ /____
- ☐ Chemo: _____ Date: ____ /____ /____
- ☐ EBRT: _____ Date: ____ /____ /____
- ☐ HDR Brachytherapy: _____ Date: ____ /____ /____
- ☐ LDR Brachytherapy: _____ Date: ____ /____ /____
- ☐ HT (eg ADT): _____ Date: ____ /____ /____
- ☐ Other: _____ Date: ____ /____ /____

FAMILY HISTORY:

FHx of prostate cancer? ☐ Yes ☐ No

Relevant Genetic Information: _____

OTHER INFORMATION

REFERRER DETAILS

Name: ..... Provider No: .....

Address: .....

Copy to: .....

Phone: ..... Fax: .....

Signature: ..... Date: .....

PLEASE TICK TO OPT OUT OF PRINTED IMAGES ☐

All images are available online

Your doctor has recommended you use San Radiology and Nuclear Medicine. You may choose another provider but please discuss this with your doctor first.

IF POSSIBLE PLEASE FAX THIS REQUEST TO SAN RADIOLOGY & NUCLEAR MEDICINE AHEAD OF MAKING YOUR APPOINTMENT

PLEASE REMEMBER TO BRING THIS REQUEST FORM AND ANY RELEVANT PREVIOUS IMAGING TO YOUR APPOINTMENT

NATA Accredited under the Diagnostic Imaging Accreditation Scheme

MULTIPARAMETRIC MRI - MEDICARE ELIGIBLE INDICATIONS & CRITERIA

MBS ITEM	INDICATIONS
DETECTION/ DIAGNOSIS 63541	Multiparametric Magnetic Resonance Imaging scan of the prostate for the detection of cancer, if the patient is referred by a urologist, radiation oncologist, or medical oncologist and the request for the scan identifies: that the patient is suspected of developing prostate cancer, due to one of the following: I. a digital rectal examination which is suspicious for prostate cancer; or II. in a person under 70 years, at least two prostate specific antigen (PSA) tests performed within an interval of 1-3 months are greater than 3.0 ng/ml, and the free/total PSA ratio is less than 25% or the repeat PSA exceeds 5.5 ng/ml; or III. in a person under 70 years, whose risk of developing prostate cancer based on relevant family history+ is at least double the average risk, at least two PSA tests performed within an interval of 1-3 months are greater than 2.0 ng/ml, and the free/total PSA ratio is less than 25%; or IV. in a person 70 years or older, at least two PSA tests performed within an interval of 1- 3 months are greater than 5.5ng/ml and the free/total PSA ratio is less than 25%. + *Relevant family history is a first degree relative with prostate cancer, or suspected of carrying a BRCA 1 or BRCA 2 mutation.* **NOTE: Benefits are payable on one occasion only in any 12 month period.**
SURVEILLANCE 63543	Multiparametric Magnetic Resonance Imaging scan of the prostate for the assessment of cancer, if the patient is referred by a urologist, radiation oncologist, or medical oncologist and the request for the scan identifies: I. the patient is under active surveillance following a confirmed diagnosis of prostate cancer by biopsy histopathology; and II. the patient is not planning or undergoing treatment for prostate cancer. **NOTE: Benefits are payable at the time of diagnosis of prostate cancer, 12 months following diagnosis and then every 3rd year thereafter or at any time, if there is a clinical concern, including PSA progression. This item is not to be used for the purposes of treatment planning or for monitoring after treatment.**

PATIENT PREPARATION:

GENERAL INSTRUCTIONS:

- Please bring your Medicare/DVA card.
- Please bring all relevant prior imaging.
- Wear comfortable warm clothing with no metal components

*** If you are DIABETIC, please ensure you inform our staff at the time of your appointment as different preparation instructions may apply.**

MRI INSTRUCTIONS:

- Please ensure the patient safety questionnaire is completed →
- A preparatory diet prior to your examination may be required as well as bowel preparation. Our team will advise you on the required preparation for your MRI scan at the time of making your appointment.

PSMA PET INSTRUCTIONS:

- No preparation required - eat and drink normally.

PSMA PET & DIAGNOSTIC CT INSTRUCTIONS:

- Fast for 4 hours unless Diabetic*. Water is allowed.

MRI PATIENT SAFETY QUESTIONNAIRE:

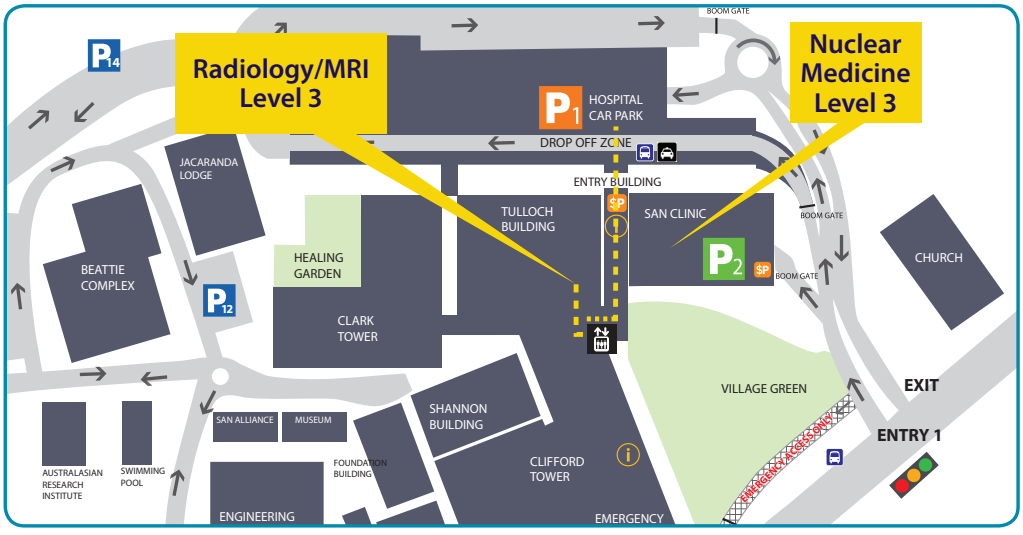
Please circle YES or NO for the following:

1. Do you have or have you had a:

Cardiac Pacemaker?	YES	NO
Implanted Cardiac Defibrillator?	YES	NO
Artificial Heart Valves or Annuloplasty Ring?	YES	NO
Neurostimulator?	YES	NO
Brain Aneurysm Clips?	YES	NO
Cochlear or Stapes Implant?	YES	NO
Other Metallic, Magnetic or Electric Implants?	YES	NO
Penile Implant?	YES	NO
Vascular Coil, Filter or Pump?	YES	NO

2. Are you Pregnant? YES NO
3. Do you have any metal objects in the eye? YES NO
4. Were you or are you a metal worker? YES NO

Please inform our reception staff if you have answered YES to ANY question, at the time of making your appointment, as further information may be required.



MY APPOINTMENT DETAILS:

Appt Date: ..... / ..... / .....

Appt Time: .....

HOW TO FIND US:

- Enter the Hospital entrance at the traffic lights on Fox Valley Road (Entry 1)
- Park in P1 for San Radiology
- Park in P2 for Nuclear Medicine