

Scheduling Form for Skin Cancer Lymphoscintigraphy

Date			
Time			
Location	BJH-North	BJH-South	BJWCH

I. To Be Completed By Referring Physician

- Patient: _____ Sex: M F
- Date of Birth: _____
- Physician: _____ Physician Phone/Beeper: _____
- Type of Cancer: _____
- Location of Tumor: (Note: SPECT/CT is likely to be useful for tumors of the head & neck where the lymphatic drainage is less predictable. SPECT/CT is only available at **BJH-North Campus**. If surgery is scheduled at the South Campus, allow an additional hour for transport).
 - Head and Neck Right Left SPECT/CT Requested
 Eyelid Ear
 Lip Nose
 Other _____
 - Extremity Right Left
 Upper If hand, give exact location _____
 Lower If foot, give exact location _____
 - Trunk Right Left
 Location: _____
- Day/Time of Surgery: Date _____ Time _____
- Location of Surgery: ___ BJH-North ___ BJH-South ___ BJWCH
- Date of Lymphoscintigraphy: Day of Surgery _____ Day Before Surgery _____
- _____
 Date _____ Person completing scheduling form _____ Telephone number _____
- Fax this form to Nuclear Medicine and call Nuclear Medicine to confirm receipt**

BJH-North:	Fax: 454-8254	Phone: 454-8945
BJH-South:	Fax: 362-0414	Phone: 362-1952
BJWCH:	Fax: 996-8716	Phone: 996-8497

II. Scheduling form reviewed by

Attending Nuclear Medicine Physician

Date

Special Instructions

Small tracer volume? Yes No