Scheduling Form for Skin Cancer Lymphoscintigraphy

Date	
Time	
Location	☐ **BJH-North** ☐ **BJH-South** ☐ **BJWCH**

I. To Be Completed By Referring Physician

1. Patient: _____ Sex: M ☐ F ☐
2. Date of Birth: _____
3. Physician: _____ Physician Phone/Beeper: _____
4. Type of Cancer: _____
5. 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).
   - A. Head and Neck Right ☐ Left ☐ SPECT/CT Requested ☐
     - Eyelid ☐ Ear ☐
     - Lip ☐ Nose ☐
     - Other ☐ _____
   - B. Extremity Right ☐ Left ☐
     - Upper If hand, give exact location _____
     - Lower If foot, give exact location _____
   - C. Trunk Right ☐ Left ☐
     - Location: _____
6. Day/Time of Surgery: Date _____ Time _____
7. Location of Surgery: ☐ BJH-North ☐ BJH-South ☐ BJWCH
8. Date of Lymphoscintigraphy: Day of Surgery ☐ Day Before Surgery ☐
9. _____ _____ _____
   Date Person completing scheduling form Telephone number
10. **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** ☐