Mallinckrodt Institute of Radiology – Barnes Jewish Hospital

Physician Request Form for Nuclear Medicine services in Patients with Hyperthyroidism and for Treatment of Euthyroid Patients with a Goiter

Instructions: Fax completed form to (314) 362-0414. We will call back with the date and time for the study. Call (314) 362-1952 if you have any questions.

Service requested (select all that apply from list below):

- ☐ **Uptake**
- ☐ **Scan** (Will be done with Tc99m Pertechnetate unless otherwise specified)
- ☐ **Other** (Specify):_____
- ☐ **Treatment next day after Uptake**
- ☐ **Treatment next day after discussion with referring physician**

Patient Information

Name: _____ **Sex:** M / F **Birthdate:** _____ (MM/DD/YYYY)

Pertinent History / Medications / Complicating Medical Problems (Please fax most recent office note):

Please fill out medical history section on page 2 and/or attach information from medical record system.

Is patient taking PTU or Tapazole? Yes / No *(Medication should be stopped at least 3 days prior to uptake measurement.)*

Has patient received iodinated contrast in last 2 months? Yes / No

Has patient had prior I-131 Therapy? Yes / No When? _____ Where? _____

For female patients**: Is there a possibility that patient is pregnant?** Yes / No

If no, please select one of the following:

☐ Premenarchal ☐ Postmenopausal ☐ S/P Tubal Ligation ☐ S/P Hysterectomy

Point of Care Pregnancy test will be obtained for all patients who may be pregnant.

Is the patient lactating or breastfeeding? Yes / No

I-131 therapy should be delayed for 4-6 weeks postpartum or after cessation of breast feeding.

***** Continue to Page 2 *****

For Nuclear Medicine Use Only

Scan	**Isotope**	**Uptake**	**Treatment**
Y / N	I-131 / I-123 / Tc-99m	Y / N	N / TBD

_____ _____ _____

Nuclear Medicine Physician Signature | Date | Nuclear Medicine Physician Name

Comments:

Scheduled Exam Starting Date: _____ **Time:** _____

Check for current form at:
http://gamma.wustl.edu/division/clinical-information.html

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Patient Information

Name: _____ **Sex:** M / F **Birthdate:** _____ (MM/DD/YYYY)

Laboratory Data

Thyroid function tests should be obtained within three weeks of uptake/treatment unless patient has known longstanding hyperthyroidism. **Location of Lab Results (Choose one):**

☐ Clinical Desktop or Allscripts ☐ Attached Copy of Results ☐ In Table Below

Test	Result	Date	Result	Date	Result	Date	Normal Range
Free T4							ng/dL
Total T4							µg/dL
Free T3							pg/dL
Total T3							ng/dL
TSH							µIU/mL

Requesting Physician Info

Name: _____ **Contact Number:** _____

Signature: _____ **Date:** _____

☐ Provide Treatment only after discussion with Requesting M.D.

Comments:

Check for current form at:
http://gamma.wustl.edu/division/clinical-information.html