Mallinckrodt Institute of Radiology – Barnes-Jewish Hospital

Physician Request Form for Nuclear Medicine Services for Treatment of Patients with Thyroid Cancer

Instructions: Fax completed form to (314) 362-1032. We will call back with the date and time for the appointment. Call (314) 362-4738 if you have any questions.

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

- ☐ **Consultation and I-131 Therapy (if appropriate) for:**
  - ☐ **Initial treatment post thyroidectomy**
  - ☐ **Subsequent treatment for persistent/recurrent disease**
- ☐ **Other** (Specify):_____

Patient Information

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

Please fax all relevant medical records related to thyroid cancer (see below):

- **Pertinent Medical and Surgical History**
- **Pathology Report from Thyroidectomy**
- **Prior Therapies for Thyroid Cancer**
- **Prior Imaging Studies for Thyroid Cancer**
- **All Laboratory Data Related to Thyroid Cancer (TSH, Tg, TgAb)**
- **All Current Medications**

Requesting Physician Info

Name: _____ **Contact Number:** _____

Signature: _____ **Date:** _____

Comments:

Check for current form at:
https://www.mir.wustl.edu/patient-care/referring-physicians/forms-resources
9/7/2023