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 and 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. **Date/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: 454-8254	Phone: 454-8945
BJWCH:	Fax: 996-8716	Phone: 996-8497

II. Scheduling form reviewed by

_____ _____

Attending Nuclear Medicine Physician ***Date***

Special Instructions

Small tracer volume? Yes No