Centre intégré universitaire de santé et de services sociaux du Centre-Ouest-de-l'Île-de-Montréal
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Patient name / Hospital card stamp / Clinic sticker

Fluorocholine HPT PET

PATIENT INFORMATION

Childbearing potential? ☐ No ☐ Yes
Claustrophobic? ☐ No ☐ Yes
Taking colchicine? ☐ No ☐ Yes

TELEPHONE _____ CELLULAR _____

EMAIL _____

BARCODE SPACE
DO NOT WRITE HERE

CLINICAL INFORMATION *(Please complete and be specific, this section is used to assign priority.)*

☐ Urgent ☐ Semi-urgent ☐ Elective

Serum parathyroid hormone:	_____	**normal range:**	_____	**date:**	_____
Serum calcium:	_____	**normal range:**	_____	**date:**	_____
24-hour urinary calcium:	_____	normal range:	_____	date:	_____
Serum 25-hydroxyvitamin D:	_____	normal range:	_____	date:	_____
Serum phosphorus:	_____	normal range:	_____	date:	_____
eGFR:	_____			date:	_____

Surgical candidate for HPT? ☐ **No** ☐ **Yes, specify:** _____
Known or referred to ENT surgeon? ☐ No ☐ Yes, specify: _____
Prior HPT surgery? ☐ No ☐ Yes, specify: _____
Prior MIBI scan or 4D-CT or neck US? ☐ No ☐ Yes, specify: _____
Patient symptomatic? ☐ No ☐ Yes, specify: _____
Osteoporosis or fragility fracture? ☐ No ☐ Yes, specify: _____
Renal stones or nephrocalcinosis? ☐ No ☐ Yes, specify: _____
Patient on thiazides or lithium? ☐ No ☐ Yes, specify: _____
Known MEN syndrome? ☐ No ☐ Yes, specify: _____
History of malignancy? ☐ No ☐ Yes, specify: _____

Please provide any clinical information not captured above:

_____

_____

_____

_____

REFERRER INFORMATION *(ATTENTION RESIDENTS AND FELLOWS: SUPERVISING STAFF NAME MUST APPEAR BELOW.)*

STAFF NAME (PRINT) _____ SIGNATURE _____ LICENSE NUMBER _____ DATE _____

TELEPHONE _____ EMAIL _____ CC _____

SERUM PTH, CALCIUM & SURGICAL CANDIDACY ARE REQUIRED. PATIENTS MUST SIGN CONSENT TO ACCESS THIS SCAN.