**(Date)** Datum: - dd/mm/gggg **/** **/**

**1. (Patient Details)** Lični podaci:

|  |  |
| --- | --- |
| **(First name)** Ime:   | **(Surname)** Prezime:   |
| **(Citizenship)** Državljanstvo:   | **(Sex)** Pol: **[ ]**  **(male)** Muški / | **[ ] (female)** Ženski |
| **(Place and date of Birth)** Mesto i datum rođenja:  | (dd/mm/gggg) **/** **/** |
| **(Weight)** Težina:  kg | **(Height)** Visina: cm |
| **(Postal address)** Adresa za korespodenciju:  |
| Tel:  | Mob:  | E-mail:  |

**2. (Referring Consultant Details)** Upućen od:

|  |  |
| --- | --- |
| **(Full name)** Ime:  | Prezime:  |
| **(Hospital/Clinic)** Zdravstvena ustanova:       |
| Tel:   | Mob:  |
| Fax:  | E-mail:  |

**3. OVAJ DEO Ispunjava klinika u Mađarskoj!**

|  |
| --- |
| **Date of receiving the PET-CT Referral Form: 200 year month day** |
| **Approving the FDG PET-CT examination request yes**  **no**  |
| **Main clinical field:**  **oncology**  **neurology**  **cardiology  other** |
| **Urgent:**  **To be scheduled** **from 200year month day Remark:** |
| **Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Signature/stamp** |

**(Information of Health State)** Informacije o zdravstvenom stanju

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **(Asthma)** Astma | yes/da | **[ ]**  | no/ne | **[ ]**  | **(Claustrophoby)** Klaustrofobija | yes/da | **[ ]**  | no/ne | **[ ]**  |
| **(Hyperthyreosis)** Hipertireoza | yes/da | **[ ]**  | no/ne | **[ ]**  | **(Allergy)** Alergija | yes/da | **[ ]**  | no/ne | **[ ]**  |
| **(Diabetes)** Dijabetes | yes/da | **[ ]**  | no/ne | **[ ]**  | **(infectious disease)** Infektivna bolest | yes/da | **[ ]**  | no/ne | **[ ]**  |
| **(Insulin Therapy)** Terapija insulinom | yes/da | **[ ]**  | no/ne | **[ ]**  | **(Blood glucose level)** Nivo šećera u krvi |  mmol/l |
| **(Pregnancy)** Trudnoća | yes/da | **[ ]**  | no/ne | **[ ]**  |  |

**(Previous)** Prethodni pregledi

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **(PET-CT examination)** PET-CT pregled | yes/da | **[ ]**  | no/ne | **[ ]**  | **(when?)** Kada? | dd/mm/gggg **/** **/**  |
| **(CT examination)** CT pregled | yes/da | **[ ]**  | no/ne | **[ ]**  | **(when?)** Kada? | dd/mm/gggg **/** **/**  |
| **(MR examination)** MR-pregled | yes/da | **[ ]**  | no/ne | **[ ]**  | **(when?)** Kada? | dd/mm/gggg **/** **/**  |

|  |
| --- |
| **(Reason for referral)** Razlog upućivanja na pregled:  |

|  |  |  |
| --- | --- | --- |
| **(What question would you like to be answered?)** Na koja pitanja biste hteli odgovore? | **(please indicate the site of primary disease or area under consideration)**Molimo označite mesto ili područje zahvaćeno bolešću |  |
| **(Past medical history, patient details, any valuable information)**Istorija bolesti, detalji o pacijentu, ostale važne informacije: |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | Datum zadnjegtretmanadan/mesec/god | **(Type)**Vrsta | Dužinatrajanja(u nedeljama) | Datum idućeg tretmanadan/mesec/god. |
| **(Surgery)** Operacija | da | **[ ]**  | ne | **[ ]**  | **/** **/**  |  |  | **/** **/**  |
| **(Chemotherapy)**Hemoterapija | da | **[ ]**  | ne | **[ ]**  | **/** **/**  |  |  | **/** **/**  |
| **(Radiotherapy)**Radioterapija | da | **[ ]**  | ne | **[ ]**  | **/** **/**  |  |  | **/** **/**  |

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(**Signature of patient or health care proxy)**Potpis pacijenta ili punomoćnika |  |  |