**(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 zadnjeg  tretmana  dan/mesec/god | **(Type)**Vrsta | | Dužina  trajanja  (u nedeljama) | Datum idućeg tretmana  dan/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 |  |  |